DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

2005 – 2006 CONTRACT

Effective June 1, 2005

FOR

Medicare/Medicaid Integration Partnership

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

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1. DEFINITIONS

The following definitions shall apply to this agreement.

1.1. **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).

1.1.1. For a rural area resident with only one Managed Care Organization (MCO) action means the denial of an enrollee's request to obtain services outside the network:

1.1.1.1. From any other provider (in terms of training, experience, and specialization) not available within the network;

1.1.1.2. From a provider not part of the network that is the main source of a service to the enrollee – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;

1.1.1.3. Because the only provider available does not provide the service because of moral or religious objections;

1.1.1.4. Because the enrollee's provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately and not all related services are available within the network; or

1.1.1.5. Because the Department of Social and Health Services (DSHS) determines that, other circumstances warrant out-of-network treatment.

1.2. **Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I).

1.3. **Ancillary Services** means health services ordered by a provider including but not limited to, laboratory services, radiology services, and physical therapy.

1.4. **Appeal** means a request for review of an action (42 CFR 438.400(b)).

1.5. **Appeal Process** means the Contractor's procedures for reviewing an action.

1.6. **Central Contract Services** means the DSHS central headquarters contracting office, or successor section or office.

1.7. **Cold Call Marketing** means any unsolicited personal contact by the Contractor with a potential enrollee or an enrollee with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

1.8. **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

1.9. **Continuity of Care** means the provision of continuous care for chronic or acute conditions through enrollee transitions in providers or service area. Transitions for enrollees with conditions requiring ongoing medical, mental health, chemical dependency or long-term-care shall be conducted in a manner that does not interrupt medically necessary care or jeopardize the enrollee's physical or mental health.

1.10. **Contract** means the entire written agreement between DSHS and the Contractor, including any Exhibits, documents and materials incorporated by reference.

1.11. **Contracts Administrator** means the manager, or successor, of Central Contract Services or successor section or office.

1.12. **Contractor** means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees and/or agents, unless otherwise stated in this agreement. For purposes of any permitted subcontract, "contractor" includes any subcontractor and its owners, officers, directors, partners, employees, and/or agents.

1.13. **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

1.14. **Coordination of Care** means the Contractor's mechanisms that ensure access to and integration of preventive, primary, acute, post acute, rehabilitation, mental health, chemical dependency, and long-term-care services into a system that appears seamless to the enrollee. For the purposes of this contract, Coordination of Care included coordination

between the services provided by the Contractor and the services the enrollee receives from other care systems.

1.15. **Covered Services** means medically necessary services, as set forth in Section 11, Schedule of Benefits, covered under the terms of this agreement.

1.16. **Debarment** means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

1.17. **DSHS or the Department** means the State of Washington Department of Social and Health Services and its employees and authorized agents.

1.18. **Dual Coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under MMIP.

1.19. **Dual Eligible** or dually eligible means clients who have been determined eligible for both Medicare and Medicaid services.

1.20. **Eligible Clients** means DSHS clients certified eligible for MMIP by DSHS, living in the service area, and eligible to enroll for services under the terms of this agreement, as described in Section 2.2.

1.21. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

1.22. **Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and are needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

1.23. **Enrollee** means a Medicaid recipient who is currently enrolled in the MMIP.

1.24. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

1.25. **Grievance Process** means the procedure for addressing enrollees' grievances.

1.26. **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the DSHS fair hearing system (42 CFR 438.400).

1.27. **Health Care Professional** means a physician or any of the following; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician (42 CFR 438.2).

1.28. **Managed Care** means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.

1.29. **Marketing** means any communication from the Contractor to a potential enrollee that can be reasonably interpreted as intended to influence them to enroll with the Contractor (CFR 438.104(a)).

1.30. **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor, that can be reasonably interpreted as intended to market to potential enrollees (42 CFR 438.104(a)).

1.31. **Medically Necessary Services** means services that are reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is not other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation, or, where appropriate, no treatment at all.

1.32. **Participating Provider** means a person, health care provider, practitioner, as defined in the Quality Improvement Program Standards, Exhibit A, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this agreement.

1.33. **Peer-Reviewed Medical Literature** means medical literature published in professional journals that submit articles for review by experts who are not

part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.34. **Personal Information** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

1.35. **Physician Group** means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups (42 CFR 434.70).

1.36. **Physician Incentive Plan** means any compensation arrangement between the **Contractor** and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this agreement (42 CFR 434.70).

1.37. **Post-stabilization Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition (42 CFR 438.114 and 42 CFR 422.113(c)).

1.38. **Potential Enrollee** means a Medicaid recipient who may voluntarily enroll in the MMIP but is not yet an enrollee (42 CFR 438.10).

1.39. **Primary Care Provider (PCP)** means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of primary care provider is inclusive of the definition of primary care physician in 42 CFR 400.203 and all Federal requirements for primary care physicians will be applicable to primary care providers as the term is used in this agreement.

1.40. **RCW** means the Revised Code of Washington. All references in this agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at http://slc.leg.wa.gov.

1.41. **Risk** means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services (42 CFR 434.2). When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined herein.

1.42. **Service Area** means King and Pierce Counties.

1.43. **Subcontract** means a written agreement between the Contractor and a subcontractor, or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this agreement.

1.44. **WAC** means the Washington Administrative Code. All references in this agreement to WAC chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at http://slc.leg.wa.gov.

2. ENROLLMENT

2.1. Service Area:

2.1.1. The Contractor shall provide the services described in this contract to clients who are determined by DSHS to reside in King or Pierce County and to be eligible for MMIP.

2.1.2. DSHS will determine whether an enrollee resides in King or Pierce County.

2.1.2.1. With the written approval of DSHS, the Contractor may expand into an additional service area at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the expansion. DSHS may withhold approval of a requested expansion, if, in DSHS' sole judgment, the requested expansion is not in the best interest of DSHS.

2.1.2.2. The Contractor may decrease its service area by giving DSHS ninety (90) calendar day's written notice. The decrease shall not be effective until the first day of the month that falls after the ninety (90) calendar days has elapsed. DSHS and the Contractor shall coordinate to ensure enrollee transition from managed care does not adversely affect continuity of care.

2.1.2.3. The Contractor shall notify enrollees affected by any service area decrease sixty (60) calendar days prior to the effective date.

Notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a service area decrease sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month, which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

2.1.3. If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, DSHS shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.1.4. DSHS shall determine, in its sole judgment, which zip codes fall within the service area.

2.1.5. DSHS will determine whether potential enrollees reside within the service area.

2.2. **Eligible Client Groups**: DSHS shall determine eligibility for enrollment under this agreement. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this agreement, and may enroll in the Medicare/Medicaid Integration Partnership (MMIP).

2.2.1. Clients who are 65 years of age or older, who are dually eligible for Medicare and Medicaid and live in the MMIP service area.

2.3. **Client Notification**: DSHS and the Contractor shall notify eligible clients of their eligibility for the MMIP at the time of program implementation, and thereafter at the time of potential enrollees' initial eligibility. DSHS shall also notify eligible clients of their rights and responsibilities as MMIP enrollees at the time of initial eligibility determination and at least annually. The Contractor and DSHS may also coordinate to provide enrollees with additional information on a more frequent basis as described in this agreement, including the Quality Improvement Program Standards, Exhibit A.

2.4. **Enrollment Period:** Subject to the provisions of Section 2.6, enrollment is continuously open. Enrollees shall have the right to disenroll from the MMIP without cause, at any time (42 CFR 434.27). For effective dates of disenrollment, see Section 2.8 of this agreement.

2.5. **Enrollment Process:** To enroll with the Contractor, the client, his/her representative or his/her responsible guardian must complete and submit a DSHS enrollment form to DSHS, or call the DSHS, Medical Assistance Administration's (MAA) toll-free enrollment number. Eligible clients may also enroll through the Aging and Disability Services Administration's (ADSA)

Home and Community Services (HCS) offices or their local Area Agency of Aging (AAA).

2.5.1. Additionally, the Contractor and participating MMIP providers may assist a potential enrollee in completing the MMIP enrollment form, including submission of the enrollment form, if the potential enrollee requests assistance. The Contractor shall ensure the potential enrollee makes an informed choice of whether to enroll in the MMIP, and that the potential enrollee or his/her representative signs the enrollment form.

2.6. **Effective Date of Enrollment:**

2.6.1. Enrollment with the Contractor shall be effective on the later of the following dates:

2.6.1.1. If the enrollment is processed on or before the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.6.1.2. If the enrollment is processed after the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.6.2. No retroactive coverage is provided under this agreement.

2.7. **Enrollment Listing and Requirements for Contractor's Response:**

2.7.1. Before the end of each month, DSHS will provide the Contractor with an electronic file, via a Health Insurance Portability and Accountability Act (HIPAA) compliant secure web based transfer system, a list of enrollees whose enrollment will be terminated at the end of that month and a list of the Contractor’s enrollees for the following month.

2.7.2. The Contractor shall have ten (10) calendar days from the receipt of the enrollment listing to notify DSHS in writing of the refusal of an application for enrollment or any discrepancy regarding DSHS' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by DSHS. The effective date of enrollment specified by DSHS shall be considered accepted by the Contractor and shall be binding if the notice is not timely or DSHS does not agree with the reasons stated in the notice. Subject to DSHS approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.7.2.1. DSHS has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

2.7.2.2. The enrollee is not eligible for enrollment under the terms of this agreement.

2.8. **Termination of Enrollment:**

2.8.1. **Voluntary Termination:** This program is a voluntary program. Receipt of Medicaid benefits is not contingent upon clients enrolling in the MMIP Eligible clients may disenroll from the MMIP at any time by calling the Medical Assistance Customer Service Center (MACSC) or contacting their case manager or social worker. The disenrollment will be effective the first of the month following the month in which the request was made. Except as provided in WAC 388-538, enrollees whose enrollment is terminated will be prospectively disenrolled. DSHS shall retroactively disenroll an enrollee only when the enrollee meets the requirements of WAC 388-538-130. DSHS shall notify the Contractor of enrollee termination. The Contractor may not request voluntary disenrollment on behalf of an enrollee.

If, at a later date, the eligible client decides to participate in the MMIP, s/he may re-enroll at any time by calling the MACSC or contacting their case manager or social worker and requesting enrollment. DSHS shall then notify the Contractor that the eligible client has re-enrolled in the program effective the first of the following month. If an enrollee is disenrolled solely because he or she loses Medicaid eligibility, and the break in eligibility is two months or less, DSHS will automatically re-enroll the enrollee with the Contractor.

2.8.2. **Involuntary Termination Initiated by DSHS for Ineligibility:** The enrollment of any enrollee under this agreement shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.8.2.1. When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.8.2.1.1. The first day of the month following the month in which the termination is processed by DSHS if the termination is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.8.2.1.2. Effective the first day of the second month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.8.3. **Involuntary Termination Initiated by DSHS for Comparable Coverage or Dual Coverage**:

2.8.3.1. The Contractor shall notify DSHS as set forth below when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.8.3.1.1. Within fifteen (15) working days when an enrollee is verified as having dual coverage, as defined in Section 1.18 of this agreement.

2.8.3.1.2. Within sixty (60) calendar days of when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

2.8.3.2. DSHS will terminate the enrollment of any enrollee with dual coverage or comparable coverage as follows:

2.8.3.2.1. When the enrollee has dual coverage that has been verified by DSHS, DSHS shall terminate enrollment retroactively to the beginning of the month of dual coverage and recoup premiums as describe in Section 3.4.

2.8.3.2.2. When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

2.8.4. **Involuntary Termination Initiated by the Contractor:**

2.8.4.1. The Contractor may request involuntary termination of an enrollee by sending written notice to DSHS as described in Section 7.4.

DSHS shall review all requests for involuntary termination and work with the Contractor on a case-by-case basis to terminate the enrollee's enrollment in the MMIP or coordinate appropriate care for the enrollee. DSHS shall approve or disapprove the request for termination within thirty (30) working days of receipt of such notice. For the termination to be effective, DSHS must approve the termination request, notify the Contractor, and disenroll the enrollee. The Contractor shall continue to provide services to the enrollee until s/he is disenrolled. DSHS will not disenroll an enrollee solely due to a request based on an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services or uncooperative or disruptive behavior resulting from his or her special needs or diminished mental capacity.

2.8.5. An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive covered services, as described in Section 10.1, at the Contractor's expense, through the end of that month.

In no event will an enrollee be entitled to receive services and benefits under this agreement after the last day of the month in which his or her enrollment is terminated, except as provided in Section 3.5. Enrollee Hospitalized at Disenrollment

2.9. Enrollment Not Discriminatory

2.9.1. The Contractor will not discriminate against enrollees or potential enrollees based on health status or need for health care services (42 CFR 438.6 (d) (3)).

2.9.2. The Contractor will not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 CFR 438.6 (d)(4)).

3. PAYMENT

3.1. **Rates/Premiums:** Subject to the provisions of Section 7.6, Sanctions, DSHS shall pay to the Contractor a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this agreement. DSHS shall pay the Contractor, based on the enrollee's rate cell, which shall be determined by DSHS, in accordance with Exhibit B which is incorporated by reference herein. The payment shall be made no later than the 15th working day of the month based on the DSHS list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and

for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.726(b) and 42 CFR 438.730(e).

The Contractor shall reconcile the payment listing with remittance advice information and submit a claim to DSHS for any amount due the Contractor within three hundred sixty five (365) calendar days of the month of service. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

3.1.2. DSHS shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

3.1.3. The Contractor shall be responsible for covered medical and long term care services provided to the enrollee in any month for which DSHS paid the Contractor for the enrollee's care under the terms of this agreement.

3.2. **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the agreement period only if DSHS, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation.

3.3. **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to DSHS for the services rendered.

3.4. **Recoupments:** Unless mutually agreed to by the parties, DSHS shall only recoup premium payments for enrollees who are:

3.4.1. Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the month in which the enrollee's death occurred.

3.4.2. Found ineligible for enrollment with the Contractor and DSHS so notifies the Contractor before the first day of the month for which the premium is paid.

3.4.3. The Contractor may recoup payments made to providers for services provided to enrollees during the period for which DSHS recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to DSHS through its FFS program.

3.5. **Enrollee Hospitalized at Disenrollment**: If an enrollee is in an acute care hospital at the time of disenrollment and the enrollee was enrolled with the MMIP Contractor on the date of admission, the Contractor shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date the enrollee is no longer confined to an acute care hospital.

3.6. **Enrollee Hospitalized at Enrollment:**

3.6.1. If an enrollee is in an acute care hospital at the time of enrollment and he or she was not enrolled in the MMIP on the day he or she was admitted to the hospital, then DSHS shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer an inpatient at the hospital.

3.6.2. If an enrollee is enrolled in the MMIP on the day he or she was admitted to an acute care hospital, then the Contractor is responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer an inpatient at the hospital.

3.7 **Third-Party Liability (TPL)**: Until such time as DSHS shall terminate the enrollment of an enrollee who has comparable coverage as described in Section 2.8.3., the services and benefits available under this agreement shall be secondary to any other medical coverage. The Contractor shall:

3.7.1. Not refuse or reduce services provided under this agreement solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

3.7.2. Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to TPL collections for enrollees available for audit and review.

3.7.3. Pay claims for covered services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

3.7.4. Communicate the requirements of this section to subcontractors that provide services under the terms of this agreement, and assure compliance with them.

3.8. **Subrogation Rights of Third-Party Liability:** Injured person means an enrollee covered by this agreement who sustains bodily injury. Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party. DSHS specifically assigns to the Contractor the DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor. The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

4. ACCESS AND CAPACITY

4.1. Network Capacity:

4.1.1. The Contractor agrees to maintain the support services and a provider network sufficient to serve the enrollee capacity in King and Pierce, Counties, consistent with the requirements of this agreement.

4.1.2. The Contractor agrees to provide the services required by this agreement through non-participating providers, at no cost to the enrollee, if its network of participating providers is insufficient to meet the needs of enrollees in a manner consistent with this agreement. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor’s network is inadequate to provide them.

4.1.3. The Contractor must submit documentation assuring adequate capacity and services as specified by DSHS as follows:

4.1.3.1. At any time there has been a significant change in services, benefits, geographic area or payments, that would affect adequate capacity and services to enrollees, or

4.1.3.2. Anytime the Contractor contemplates enrollment of a new population in the MMIP.

4.2. **Service Delivery Network:** When establishing a provider network to provide services to enrollees under this Contract , the Contractor must consider the following:

4.2.1. The anticipated enrollment;

4.2.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the Medicare and Medicaid populations represented by MMIP enrollees;

4.2.3. The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;

4.2.4. The number of network providers who are not accepting new Medicare and/or Medicaid enrollees;

4.2.5. The geographic location of providers and MMIP enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for MMIP enrollees with disabilities.

4.3. **Provider Selection:** The Contractor must have written policies and procedures for selection and retention of providers, including at minimum:

4.3.1 A documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the Contractor;

4.3.2 Provider selection policies and procedures, consistent with 42 CFR 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

4.3.3 Prohibition against employment contract with providers excluded from participation in Federal health care programs under federal law.

4.3.4 The Credentialing and Re-credentialing System must:

4.3.4.1 Have written credentialing and re-credentialing policies and procedures, including criteria;

4.3.4.2 Identify verification sources and provide documentation of results;

4.3.4.3 Contain delegation agreements for subcontracts that comply with National committee on Quality Assurance (NCQA) requirements for credentialing delegation agreements.

4.4. **Timely Access to Care**: The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services. The Contractor shall ensure that:

4.4.1. Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Contractor has served only Medicaid enrollees;

4.4.2. Mechanisms are established to ensure compliance with access standards by providers;

4.4.3. Providers are monitored regularly to determine compliance with access standards; and

4.4.4. Corrective action is initiated if there is a failure to comply.

4.5. **Utilization Management**:

4.5.1. Providers who make UM decisions must have education, training or professional experience in medical or clinical practice and have a current license to practice.

4.5.2. The Contractor shall use providers with appropriate qualifications to review denials based upon medical necessity, i.e., mental health specialists (mental health specialists are not required to be licensed but must meet requirements set forth in WAC 388-865), pharmacists, chemical dependency professionals, etc.;

4.5.3. The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

4.6. **24/7 Availability**: The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis. These services may be provided directly by the Contractor or may be delegated to subcontractors.

4.6.1. Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of medical condition.

4.6.2. Emergency Care.

4.6.3. Authorization of out-of-area urgent care.

4.7. **Appointment Standards**: The Contractor **shall** comply with appointment standards that are no longer than the following:

4.7.1. Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or an alternate practitioner within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or adult immunizations.

4.7.2. Non-urgent, symptomatic (i.e., routine care) office visit shall be available from the enrollee's PCP or an alternative practitioner within seven (7) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

4.7.3. Urgent, symptomatic office visits shall be available within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

4.7.4. Emergency medical care shall be available 24 hours per day, seven days per week.

4.8. **Provider Network - Distance Standards**: The Contractor network of providers shall meet the distance standards below in the Contractor's service area. DSHS may, at its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require supporting the request. If the closest qualified provider is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest qualified provider may be a provider not participating with the Contractor.

4.8.1. PCP

Urban: 2 within 10 miles for 90% of MMIP enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of MMIP enrollees in the Contractor's service area.

4.8.2. Hospital

Urban/Rural: 1 within 25 miles for 90% of MMIP enrollees in the Contractor's service area.

4.8.3. Pharmacy

Urban: 1 within 10 miles for 90% of MMIP enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of MMIP enrollees in the Contractor's service area.

4.9. **Access to Specialty Care:** The Contractor shall provide all medically necessary specialty care for enrollees in the service area. If an enrollee needs specialty care from a specialist who is not available within the Contractor's provider network, the Contractor shall obtain the necessary services from a qualified specialist outside the Contractor's provider network.

4.10. **Equal Access for Enrollees and Potential Enrollees with Communication Barriers:** The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access.

4.10.1. **Oral Information:**

4.10.1.1. Subject to the remainder of this section, the Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English for all interactions between the enrollee or potential enrollee and the Contractor or any of its providers including, but not limited to, customer services, all appointments with any provider for any covered service, emergency services, and all steps necessary to file grievances and appeals.

4.10.1.2. The Contractor is responsible for payment for interpreter services for plan administrative matters including, but not limited to handling enrollee grievances and appeals.

4.10.1.3. DSHS is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient visits and DSHS fair hearings.

4.10.1.4. Hospitals are responsible for payment for interpreter services during inpatient stays.

4.10.1.5. Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

4.10.1.6. Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired.

4.10.2. **Written Information:**

4.10.2.1. The Contractor shall provide all generally available and client specific written materials in a form which may be understood by each individual enrollee and potential enrollee.

4.10.2.2. If 5% or more potential enrollees in a service area speak one language other than English, then generally available materials will be translated into that language.

4.10.2.3. The Contractor may meet this requirement by doing one of the following:

4.10.2.3.1. Translating the material into the enrollee's or potential enrollee’s primary reading language.

4.10.2.3.2. Providing the material on tape in the enrollee's or potential enrollee’s primary language.

4.10.2.3.3. Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

4.10.2.3.4. Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee’s acceptance of the alternative.

4.10.2.3.5. Providing the material in English, if the Contractor documents the enrollee's or potential enrollee’s preference for receiving material in English.

4.10.2.4. The Contractor shall ensure that all written information provided to enrollees or potential enrollees is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level. Generally available, written materials shall be consumer tested.

4.11. **Americans with Disabilities Act:** The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

4.12. **Order of Acceptance:** The Contractor shall accept enrollees in the order in which they apply. The Contractor shall accept clients who enroll in the MMIP in accord with this agreement, WAC 388-538, and WAC 388-542, except as specifically provided in Section 2.7.

No eligible client shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, the existence of a pre-existing physical or mental condition, including hospitalization or the expectation of the need for frequent or high cost care.

4.13. **Provider Network Changes:**

4.13.1. The Contractor shall give DSHS a minimum of ninety (90) calendar days prior written notice, in accord with Section 7.5, Notices, of the loss of a material medical provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor’s current enrollees and/or the number of enrollees the Contractor has agreed to serve in a service area.

4.13.2. The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 CFR 438.10(f)(5). Enrollee notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

4.14. **Women's Health Care Services:** In the provision of women's health care services, the Contractor shall comply with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

4.15. **Cultural Consideration:** The Contractor shall participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).

5. QUALITY OF CARE

5.1. Quality Improvement Program:

5.1.1. The Contractor shall maintain a quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees that meets

5.1.1.1. The provisions of 42 CFR 438 Subpart D – Quality Assessment and Performance Improvement;

5.1.1.2. The Medicaid Managed Care Protocols located at www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp;

5.1.1.3. The provisions of this agreement; and

5.1.1.4. The Quality Improvement Program Standards, Exhibit A.

5.1.2. The Contractor shall, during an annual review or upon request by DSHS or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to enrollees.

5.1.3. The Contractor shall include the following basic elements in its Quality Improvement program (42 CFR 438.240(b)):

5.1.3.1. Conduct performance improvement projects described herein.

5.1.3.2. Have in effect mechanisms to detect both underutilization and over utilization of services.

5.1.3.3. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees, including individuals with special health care needs.

5.1.3.4. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees for geriatric and specialty services that are consistent with existing standards published by the respective DSHS divisions, including the quality improvement standards contained in the ADSA Home and Community Based Services waiver, the terms of the plan of care developed in accordance with the ADSA assessment, the Washington State Medicaid Plan and applicable WAC.

5.1.3.5. Include appropriate specialty practitioners in the oversight of QAPI.

5.1.3.6. Clearly defined QAPI structures, processes and assignments which include:

5.1.3.6.1. A written description of QAPI;

5.1.3.6.2. An oversight committee;

5.1.3.6.3. A work plan;

5.1.3.6.4. An annual evaluation;

5.1.3.6.5. A designated specialist with substantial involvement in the implementation of the long term care aspects of the QAPI;

5.1.3.6.6. A description of resources needed for the implementation of QAPI.

5.2. **Accreditation:** If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to DSHS. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with DSHS, Department of Health (DOH), Office of the Insurance Commissioner (OIC) and Health Care Authority (HCA) as needed to reduce duplicate work for both the Contractor and the state.

5.3. **Performance Improvement Projects**:

5.3.1. The Contractor shall conduct Performance Improvement Projects (PIPs) as described in 42 CFR 438.240 and as specified in the CMS protocol at: www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp. The projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Annually, the Contractor shall:

5.3.1.1. Measure performance using objective quality indicators;

5.3.1.2. Implement a system of interventions to achieve improvement in quality;

5.3.1.3. Evaluate the effectiveness of the interventions;

5.3.1.4. Plan and initiate activities for increasing or sustaining improvement;

5.3.1.5. Report the status and results of each project to DSHS; and

5.3.1.6. Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year;

5.3.2. The Contractor shall conduct at least three clinical PIPs in the following areas, dependent upon the most relevant needs of the population;

5.3.2.1. Falls: If the Contractor's rate of screening for falls, which resulted in a serious injury, is below 85%, the Contractor shall implement a DSHS-approved clinical PIP designed to increase the rate of screening to 90%.

5.3.2.2. Pneumococcal Vaccination: If the Contractor's percent of enrollees who were offered or received pneumococcal vaccine in the past five years or after the age of 65 falls below 75%, the Contractor shall implement a DSHS approved clinical PIP designed to increase the amount of enrollees who were offered or received pneumococcal vaccine in the past five years or after the age of 65 by 2%.

5.3.2.3. Influenza Vaccination: If the Contractor's percent of enrollees who were offered or received influenza vaccine during the flu season (Oct-Mar) falls below 75%, the Contractor shall implement a DSHS approved clinical PIP designed to increase the amount of enrollees who were offered or received influenza vaccine by 2%.

5.3.2.4. Depression: If the Contractor's percent of enrollees who received depression screening with new episodes of sad mood, feeling down, insomnia or difficulties with sleep, apathy or loss of interest in pleasurable activities, complaints of memory loss, unexplained weight loss greater than 5 percent in the past month or 10 percent in the past year or unexplained fatigues or low energy is below 75%, the Contractor shall implement a DSHS approved clinical PIP designed to increase the amount of depression screening by 2%.

5.3.2.5. Dementia: If the Contractor's percent of enrollees who received dementia screening falls below 85%, the Contractor shall

implement a DSHS approved clinical PIP designed to increase the amount of dementia screening by 2%.

5.3.3. If none of the five clinical PIPs listed above (Falls, Pneumococcal Vaccination, Influenza Vaccination; Depression, Dementia) are determined necessary because the Contractor has met or exceeded the baseline definition, the Contractor shall conduct at least three clinical PIPs determined by the most relevant needs of the population

5.3.3.1. The Contractor shall provide documentation showing the relevance of those PIPs instigated on behalf of improving clinical care.

5.3.4. The Contractor shall conduct at least two non-clinical PIPs in an area of services identified by DSHS and the Contractor as an opportunity and relevant to the MMIP population.

5.4. **Independent Quality Review Organization (EQRO) :** The Contractor shall allow a qualified External Quality Review Organization (EQRO), contracted by DSHS, to perform an annual external independent review covering quality outcomes, timeliness of and access to, the services covered by this contract, as described in 42 CFR 438, Subpart E.

5.5. **Consumer Assessment of Health Plans Survey (CAHPS®):**

5.5.1. In 2006 the Contractor shall conduct a CAHPS survey of adult Medicaid and Medicare members enrolled in the MMIP. The Contractor shall:

5.5.1.1. Ensure the survey sample frame consists of all Medicaid and Medicare non-commercial adult plan members (not just subscribers), with Washington State addresses;

5.5.1.2. Coordinate with MAA's HEDIS auditor to validate the sample frame for the CAHPS survey. Provide any additional data to assist MAA's auditor in completing the validation worksheet described in the Administering or Validating Surveys Protocol found at: www.cma.hhs.gov/medicaid/managedcare/mcegrpmp.asp

5.5.1.3. Contract with an NCQA certified vendor qualified to administer the CAHPS survey and conduct the survey according to the NCQA protocol.

5.5.1.4. Conduct a mixed methodology (mail and phone surveys).

5.5.2. DSHS must approve the questionnaire format, questions and question placement, plus supplemental and/or custom questions for the 2006 survey before the survey field period.

5.5.3. The Contractor shall include performance language in subcontracts that require a subcontractor to target at least a 45% response rate.

5.5.4. The Contractor shall submit the following information to DSHS:

5.5.4.1. Final disposition report by June 30, 2006;

5.5.4.2. A copy of the data set according to 2006 NCQA/CAHPS standards to DSHS by June 30, 2006;

5.5.4.3. Final report with findings and analysis for each CAHPS composite and questions relating to the composite and the four overall satisfaction ratings by October 31, 2006;

5.5.4.4. Banner tables or top line responses per all questions in the CAHPS survey by October 31,2006;

5.5.4.5. Overall response rate

5.6. **Provider Education:** The Contractor shall maintain a system for keeping participating practitioners and providers informed about:

5.6.1. Covered services for enrollees served under this agreement;

5.6.2. Coordination of care requirements; and

5.6.3. DSHS policies as related to this agreement.

5.6.4. Interpretation of data from the quality improvement program (42 CFR 434.34(d)).

5.6.5. Practice guidelines (see Section 5.9)

5.7. **Claims Payment Standards:** The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 90% of clean claims within thirty (30) calendar days of receipt, 95% of all claims within sixty (60) of receipt and 99% of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

5.7.1. A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

5.7.2. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

5.7.3. The date of receipt is the date the Contractor receives the claim from the provider.

5.7.4. The date of payment is the date of issuance of the check or other form of payment.

5.8. **Health Insurance Portability and Accountability Act (HIPAA)**: The Contractor and the Contractor's subcontractors shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164. The Contractor and the Contractor's subcontractors shall fully cooperate with DSHS efforts to implement HIPAA requirements.

5.9. **Practice Guidelines:** The Contractor shall adopt practice guidelines that meet the following requirements (42 CFR 438.6):

5.9.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

5.9.2. Consider the needs of enrollees and support client and family involvement in care plans;

5.9.3. Are adopted in consultation with contracting health care professionals;

5.9.4. Are reviewed and updated periodically as appropriate;

5.9.5. Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees;

5.9.6. Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply;

5.10. **Advance Directives:**

5.10.1. The Contractor shall maintain written policies and procedures for advance directives that meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I. The Contractor's advance directive policies and procedure shall be disseminated to all affected providers, enrollees, DSHS, and, upon request, potential enrollees.

5.10.2. The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

5.10.2.1. Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

5.10.2.2. Identify the state legal authority permitting such objection.

5.10.2.3. Describe the range of medical conditions or procedures affected by the conscience objection.

5.10.3. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

5.10.4. The Contractor's policies and procedures must require, and the Contractor must ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive.

5.10.5. The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

5.10.6. The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.

5.10.7. The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes

an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts.

5.10.8. The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this agreement to conscientiously object.

5.10.9. The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements.

5.11. **Health Information Systems:** The Contractor shall maintain and shall require subcontractors to maintain a health information system that complies with the requirements of 42 CFR 438.242 and provides the information necessary to meet the Contractor's obligations under this agreement. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The health information system must:

5.11.1. Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance, and appeals, and disenrollments for other than loss of Medicaid eligibility.

5.11.2. Ensure data received from providers is accurate and complete by:

5.11.2.1. Verifying the accuracy and timeliness of reported data;

5.11.2.2. Screening the data for completeness, logic, and consistency; and

5.11.2.3. Collecting service information on standardized formats to the extent feasible and appropriate.

5.11.3. The Contractor shall make all collected data available to DSHS and The Center for Medicare and Medicaid Services (CMS) upon request.

6. **REPORTING REQUIREMENTS**:

6.1. **Certification Requirements:** Any information and/or data required by this agreement and submitted to DSHS after April 1, 2005 shall be certified by the Contractor as follows (42 CFR 438.600 through 42 CFR 438.606):

6.1.1. Source of certification: The information and/or data shall be certified by one of the following:

6.1.1.1. The Contractor's Chief Executive Officer

6.1.1.2. The Contractor's Chief Financial Officer

6.1.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer

6.1.2. Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

6.1.3. Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

6.1.4. Data that must be certified include documents specified by DSHS and include enrollment information, encounter data and other information contained in contracts or proposals, as required by DSHS.

6.2. **Health plan Employer Data and Information Set (HEDIS®) Measures:** In accordance with 7.4 Notices, the Contractor shall report to DSHS, the following HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by DSHS.

6.2.1. HEDIS® measures will be audited by MAA's HEDIS® auditor according to HEDIS® specifications for the calculation of performance measures. The 2006 Partial HEDIS® Compliance Audit Standards, Policies and Procedures will be employed for the assessment of HEDIS® measures.

6.2.2. No later than June 15th of 2006 and then June 15th of each year, the following HEDIS® measures shall be submitted electronically to DSHS and a second copy shall be submitted to the EQRO designated by DSHS, using the NCQA-supplied data reporting tool:

6.2.2.1. Colorectal cancer screening;

6.2.2.2. Ambulatory Care;

6.2.2.3. Comprehensive Diabetes Care;

6.2.2.4. Inpatient Utilization – General Hospital/Acute Care

6.2.3. HEDIS-Like Measures: CMS has given Evercare permission to use HEDIS like quality indicators in lieu of other reporting requirements. DSHS agrees to the use of the following indicators as well. These measures must be collected and reported to DSHS in accordance with the agreed upon Federal measure specifications and MDS coding instructions, along with a model reporting instrument that Evercare is using to submit the data to CMS. In addition to reporting the below quality indicators to DSHS by September 1, 2006 (for reporting year 2005), Evercare must submit the Federal measure specifications, MDS coding instructions and model reporting instrument to DSHS by September 1, 2006.

6.2.3.1. Falls – Percent of Enrollees screened for falls which resulted in serious injury;

6.2.3.2. Pneumococcal Vaccination – Percent of enrollees offered or received pneumococcal vaccine in past 5 years or once after the age of 65.

6.2.3.3. Influenza Vaccination – Percent of enrollees offered or received influenza vaccine during the flu season (Oct-Mar) and in the past year.

6.2.3.4. Depression – Enrollees with new episode of sad mood, feeling down, insomnia or difficulties with sleep, apathy or loss of interest in pleasurable activities, complaints of memory loss, unexplained weight loss greater than 5 percent in the past month or 10 percent in the past year or unexplained fatigues or low energy, who receive depression screening.

6.2.3.5. Chronic dementia – Percent of enrollees screened for chronic dementia.

6.3. **Encounter Data:** The Contractor shall submit encounter data.

6.3.1. Encounter data includes all services delivered to enrollees. DSHS collects and uses this data for many reasons such as federal reporting; rate setting and risk adjustment; managed care quality improvement

program, verification of services, utilization patterns and access to care; DSHS hospital rate setting; and research studies. The Contractor shall comply with the Encounter Data Guide for Managed Care Organizations published by DSHS.

6.3.2. DSHS may change the Encounter Data Guide for Managed Care Organizations with one hundred and fifty (150) calendar days written notice to the Contractor. The Encounter Data Guide for Managed Care Organizations may be changed with less than one hundred and fifty (150) calendar days notice by mutual agreement of the Contractor and DSHS. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

6.4. **Integrated Provider Network Database (IPND):** The Contractor shall report their complete provider network, to include all current contracted providers, monthly, beginning in March, 2005, to DSHS through the designated data management contact in accord with the Provider Network Reporting Requirements published by DSHS at http://maa.dshs.wa.gov/healthyoptions/IPND.

6.5. **FQHC/RHC Report:** The Contractor shall provide DSHS with information related to subcontracted federally-qualified health centers (FQHC) and rural health clinics (RHC), as required by the DSHS Licensed Health Carrier Billing Instructions, published by DSHS.

6.6. **Enrollee Mortality:** The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to DSHS upon request. The Contractor shall assist DSHS in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.7. **Actions, Grievances and Appeals:** The Contractor shall maintain a record of all actions, grievances and appeals, including actions, grievances and appeals handled by a delegated entity, and independent review of adverse decisions by an independent review organization. The Contractor shall provide a report of complete actions, grievances and appeals to DSHS biannually for the prior six months. The report for the six months ending March 31st is due no later than June 1st and the report for the six months ending September 30th is due no later than November 1st. The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities. Delegated actions, grievances and appeals are to be integrated into the Contractor's report. Data shall be reported in the DSHS and Contractor agreed upon format. The report medium shall be specified by DSHS. Reporting of actions shall include all denials or limited authorization of a requested service, including

the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers. Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action. The records shall be sorted using the sort keys identified and shall include, at a minimum:

6.7.1. Name of Program: MMIP (Primary Sort Key)

6.7.2. Name of the delegated entity, if any

6.7.3. Enrollee Identifier (three separate fields):

6.7.3.1. Patient Identification Code (PIC) (preferred) or

6.7.3.2. Enrollee Name and Enrollee Birthday: If PIC not reported

6.7.4. Name of Practitioner (Optional)

6.7.5. Type of Practitioner (Optional)

6.7.6. Type (Secondary Sort Key):

6.7.6.1. Action

6.7.6.2. Grievance

6.7.6.3. Appeal - First Level

6.7.6.4. Appeal - Second Level

6.7.6.5. IRO

6.7.7. Expedited: Yes or No

6.7.8. Grievance, Appeal or IRO Issue

6.7.9. Category of Action or Grievance

6.7.10. Action Reason

6.7.11. Resolution of Grievance, Appeal or IRO

6.7.12. Action Date

6.7.13. Receipt Date of Grievance, Appeal or IRO

6.7.14. Date of Resolution of Grievance, Appeal, or IRO

6.7.15. Date written notification of Action or Grievance, Appeal or IRO outcome sent to enrollee and practitioner

6.8. **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this agreement, to DSHS for review and approval by February 1, 2005 and by January 31st of each year of this agreement thereafter, beginning in 2006. The formulary shall be submitted to:

Siri Childs, Pharm D, Pharmacy Policy Manager (or her successor)
Division of Medical Management
Medical Assistance Administration
PO Box 45506
Olympia, WA 98504-5506
childsa@dshs.wa.gov

6.9. **Fraud and Abuse:** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days to DSHS according to Section 7.4, Notices. The report shall include the following information:

6.9.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.

6.9.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.

6.9.3. Nature of complaint.

6.9.4. Estimate of the amount of funds involved.

6.9.5. Legal and administrative disposition of case.

6.10. **Reporting of Enrollee Abuse:** The Contractor shall report all instances of suspected abuse, abandonment, neglect and/or exploitation to one of the following toll free numbers.

If the enrollee or other alleged victim resides in:

- King County, call: 1-866-221-4909
- Pierce County, call: 1-800-442-5129

If the alleged victim lives in an area of the state other than those mentioned above, call 1-866-END-HARM.

On a quarterly basis, the Contractor shall report all instances of suspected abuse, abandonment, neglect or exploitation to the ADSA Program Manager, including enrollee name, nature of the abuse, abandonment, neglect or exploitation and any action taken by the contractor in addition to calling the toll free number.

6.11. **Five Percent Equity:** The Contractor shall provide the DSHS, Contract Manager assigned to the Contractor a list of persons with a beneficial ownership of more than 5% of the Contractor's equity no later than February 28th of each year of this agreement.

7. GENERAL TERMS AND CONDITIONS

7.1. **Complete Agreement:** This agreement incorporates Exhibits to this agreement and the DSHS billing instructions applicable to the Contractor. All terms and conditions of this agreement are stated in this agreement and its incorporations. No other agreements, oral or written, are binding.

7.2. **Modification:** This agreement may only be modified by mutual consent of the parties. All modifications shall be set forth in written contract amendments issued by DSHS.

7.3. **Waiver:** The failure of either party to enforce any provision of this agreement shall not constitute a waiver of that or any other provision, and will not be construed to be a modification of the terms and conditions of the agreement unless incorporated into the agreement with an amendment.

7.4. **Notices:** Whenever one party is required to give notice to the other under this agreement, it shall be deemed given if mailed by United States Postal Service, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

In the case of notice to the Contractor, notice will be sent to the point of contact submitted to DSHS on the Contractor Intake Form
In the case of notice to DSHS:

Bill Moss,
Department of Social and Health Services
Home and Community Services Division
P.O. Box 45600
Olympia, WA 98504-5600

Said notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing as aforesaid a notice stating the change and setting forth the new address, which shall be effective on the

tenth day following the effective date of such notice unless a later date is specified.

7.5. **Force Majeure:** If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order, or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternate and, to the extent practicable, comparable performance. Nothing in this clause shall be construed to prevent DSHS from terminating this agreement for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

7.6. **Sanctions:**

7.6.1. DSHS will notify the Contractor in writing of the basis and nature of the any sanctions and, if applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in Section 7.23, Disputes, if the Contractor disagrees with DSHS' position.

7.6.2. If the Contractor fails to meet one or more of its material obligations under this agreement, DSHS may impose sanctions by withholding up to five percent of payments to the Contractor rather than terminating the agreement.

DSHS may withhold payment from the end the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

7.6.3. DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions, in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for:

7.6.3.1. Failing to provide medically necessary services that the Contractor is required to provide, under law or under this agreement, to an enrollee covered under this agreement.

7.6.3.2. Imposing premiums or charges on enrollees that are in excess of the premiums or charges permitted under law or under this agreement.

7.6.3.3. Acting to discriminate among enrollees based on their health status or need for health care services. This includes termination of

enrollment or refusal to reenroll a recipient, except as permitted under law or under this agreement, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

7.6.3.4. Misrepresenting or falsifying information that it furnishes to CMS or to the State.

7.6.3.5. Misrepresenting or falsifying information that it furnishes to an enrollee, potential enrollee, or health care provider.

7.6.3.6. Failing to comply with the requirements for physician incentive plans.

7.6.3.7. Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

7.6.3.8. Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

7.6.3.9. Intermediate sanctions may include:

7.6.3.9.1. Civil monetary penalties in the following amounts:

7.6.3.9.1.1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

7.6.3.9.1.2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

7.6.3.9.1.3. A maximum of $15,000 for each potential enrollee DSHS determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

7.6.3.9.1.4. A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under MMIP. DSHS will deduct from the penalty the amount charged and return it to the enrollee.

7.6.3.9.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. DSHS will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accordance with RCW 48.44.033.

7.6.3.9.3. Suspension of all new enrollments after the effective date of the sanction. Current enrollees will be notified of the sanctions and that they may terminate enrollment at any time.

7.6.3.9.4. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DSHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

7.7. **Assignment of this Agreement:** This agreement, including the rights, benefits, and duties herein, shall be binding on the parties and their successors and assignees but shall not be assignable by either party without the express written consent of the other. Nor shall any claim, pertinent to this agreement, against one of the parties be assignable without the express written consent of the other.

7.8. **Headings Not Controlling:** The headings and the index used herein are for reference and convenience only, and shall not enter into the interpretation thereof, or describe the scope or intent of any provisions or sections of this agreement.

7.9. **Order of Precedence:** In the interpretation of this agreement and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible, the following order of precedence shall apply:

7.9.1. Title XIX of the federal Social Security Act of 1935, as amended, and it's implementing regulations; as well as federal statutes and regulations concerning the operation of Health Maintenance Organizations.

7.9.2. State of Washington statutes and regulations concerning the operation of the DSHS programs participating in this contract, including but not limited to RCW Title 74; WAC 388-538 (Managed Care); and WAC 388-71 (Long Term Care).

7.9.3. State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors and Disability Insurance Carriers.

7.9.4. The terms and conditions of this agreement, including any Exhibits as indicated on page one of the agreement.

7.9.5. Any other material incorporated herein by reference.

7.10. **Proprietary Rights:** DSHS recognizes that nothing in this agreement shall give DSHS rights to the systems developed or acquired by the Contractor during the performance of this agreement. The Contractor recognizes that nothing in this agreement shall give the Contractor rights to the systems developed or acquired by DSHS during the performance of this agreement.

7.11. **Covenant Against Contingent Fees:** The Contractor promises that no person or agency has been employed or retained on a contingent fee for the purpose of seeking or obtaining this agreement. This does not apply to legitimate employees or an established commercial or selling agency maintained by the Contractor for the purpose of securing business. In the event of breach of this clause by the Contractor DSHS may at its discretion: a) annul the agreement without any liability; or b) deduct from the agreement price or consideration or otherwise recover the full amount of any such contingent fee.

7.12. **Records Maintenance and Retention:**

7.12.1. **Maintenance:** The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this agreement. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this agreement.

7.12.2. **Retention:** All records and reports relating to this agreement shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this agreement or, in the event that this agreement is renewed, six (6) years after the renewal date. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

7.13. **Access to Facilities and Records:** The Contractor and its subcontractors shall cooperate with medical and financial audits performed by duly authorized representatives of DSHS, the state of Washington Auditor's

Office, the federal Department of Health and Human Services, the federal Government Accountability Office, and the federal Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the financial and medical records pertinent to this agreement to monitor and evaluate performance under this agreement, including, but not limited to, the quality, cost, use and timeliness of services (42 CFR 434.52), and assessment of the Contractor's capacity to bear the potential financial losses (42 CFR 434.58). The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this agreement for Medicaid fraud investigators.

7.14. **Solvency:**

7.14.1. The Contractor shall have a Certificate of Registration as a Health Maintenance Organization, a Health Care Service Contractor or a Life and Disability Insurance Carrier from the Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of RCW 48.44 or RCW 48.46, as amended, plus any implementing regulations.

7.14.2. The Contractor shall notify DSHS immediately upon being notified by OIC that it is to report financial information quarterly or monthly and provide DSHS with the same information provided to OIC in response to any OIC request. The Contractor shall deliver all required information and notices to DSHS at the address listed in 7.4 Notices. The Contractor agrees that DSHS may at anytime access any information related to the Contractor's financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.

7.14.3. The Contractor shall provide DSHS with the Contractor's audited financial statements as soon as they become available to the Contractor. Financial statements shall be delivered to the address list in 7.4 Notices.

7.14.4. If the Contractor becomes insolvent during the term of this agreement:

7.14.4.1. The state of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor.

7.14.4.2. In accord with Section 10.12 Prohibition on Enrollee Charges for Covered Services, under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services.

7.14.4.3. The Contractor shall, in accord with RCW 48.44.055 or RCW 48.46.245, provide for the continuity of care for enrollees.

7.15. **Compliance with All Applicable Laws and Regulations:** In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed or that come into effect during the term of the agreement (42 CFR 438.100(d). This includes, but is not limited to:

7.15.1. Title XIX and Title XXI of the Social Security Act.

7.15.2. Title VI of the Civil Rights Act of 1964.

7.15.3. Title IX of the Education Amendments of 1972, regarding any education programs and activities.

7.15.4. The Age Discrimination Act of 1975.

7.15.5. The Rehabilitation Act of 1973

7.15.6. The Americans with Disabilities Act.

7.15.7. All applicable OIC statutes and regulations.

7.15.8. All local, state, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this agreement, including but not limited to:

7.15.8.1. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS, and the EPA.

7.15.8.2. Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.

7.15.8.3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

7.15.8.4. Those specified in Title 18 for professional licensing.

7.15.9. Liability insurance requirements.

7.15.10. Reporting of suspected abuse, abandonment, neglect, and exploitation as required by RCW 26.44.030 and RCW 74.34.035.

7.15.11. Industrial insurance coverage as required by Title 51 RCW.

7.15.12. EEO Provisions.

7.15.13. Copeland Anti-Kickback Act.

7.15.14. Davis-Bacon Act.

7.15.15. Byrd Anti-Lobbying Amendment.

7.15.16. Any other requirements associated with the receipt of federal funds.

7.16. **Nondiscrimination:** The Contractor shall comply with all federal and state nondiscrimination laws and regulations.

7.17. **Review of Client Information:** DSHS agrees to provide the Contractor with written client information, which DSHS intends to distribute to all or a class of clients.

7.18. **Contractor Not Employees of DSHS:** The Contractor acknowledges and certifies that none of its directors, officers, partners, employees, and agents are officers, employees, or agents of DSHS or the state of Washington. Neither the Contractor nor any of its directors, officers, partners, employees, or agents shall hold themselves out as or claim to be an officer, employee, or agent of DSHS or the state of Washington by reason of this agreement. Neither the Contractor nor any of its directors, officers, partners, employees, or agents shall claim any rights, privileges, or benefits that would accrue to a civil service employee under RCW 41.06.

7.19. **DSHS Not Guarantor:** The Contractor acknowledges and certifies that neither DSHS nor the State of Washington are guarantors of any obligations or debts of the Contractor.

7.20. **Mutual Indemnification and Hold Harmless:** Each party shall be responsible for, and shall indemnify and hold the other party harmless from, all claims and/or damages to persons and/or property resulting from its own negligent acts and omissions. The Contractor shall indemnify and hold harmless DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this agreement.

7.21. **Disputes:** When a dispute arises over an issue that pertains in any way to this agreement, the parties agree to the following process to address the dispute:

7.21.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor.

7.21.2. If the Contractor is not satisfied with the outcome of the resolution with the Contract Manager, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the outcome, to:

MaryAnne Lindeblad, Director (or her successor)
Division of Program Support
Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45530
Olympia, WA 98504-5530

The Director may request additional information from the Contract Manager and/or the Contractor. The Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor according to Section 7.4.

7.21.3. When the Contractor disagrees with the review decision of the Director, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the Director, in writing, within ten (10) working days of the Contractor's receipt of the Director's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

7.21.4. Both parties agree to make their best efforts to resolve disputes arising from this agreement and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this agreement.

7.22. **Governing Law and Venue:** The laws of the state of Washington shall govern this agreement. In the event of a lawsuit involving this agreement, venue shall be proper only in Thurston County, Washington. By execution of this agreement, the Contractor acknowledges the jurisdiction of the courts of the state of Washington regarding this matter.

7.23. **Severability:** If any provision of this agreement, including any provision of any document incorporated by reference, shall be held invalid, that invalidity shall not affect the other provisions of the agreement. To that end, the provisions of this agreement are declared to be severable.

7.24. **Excluded Persons:**

7.24.1. The Contractor may not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or have an employee, consultant or contractor who is significant or material to the provision of services under this agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d) (1)). A list of excluded parties is available on the following Internet website: www.arnet.gov/epls.

7.24.2. By entering into this agreement, the Contractor certifies that it does not knowingly have anyone who is an excluded person, or is affiliated with an excluded person, as a director, officer, partner, employee, contractor, or person with a beneficial ownership of more than 5% of its equity. The Contractor is required to notify DSHS when circumstances change that affect such certification.

7.24.3. The Contractor is not required to consult the excluded parties list, but may instead rely on certifications from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than 5% of the Contractor's equity, that they are not debarred or excluded from a federal program.

7.25. **Fraud and Abuse Requirements - Policies and Procedures:**

7.25.1. The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse (42 CFR 438.608(a)).

7.25.2. The Contractor’s arrangements or procedures shall include the following (42 CFR 438.608(b)(1)):

7.25.2.1. Written policies, procedures, and standards of conduct that articulates the Contractor’s commitment to comply with all applicable Federal and State standards.

7.25.2.2. The designation of a compliance officer and a compliance committee that is accountable to senior management.

7.25.2.3. Effective training for the compliance officer and the Contractor's employees.

7.25.2.4. Effective lines of communication between the compliance officer and the Contractor's staff.

7.25.2.5. Enforcement of standards through well-publicized disciplinary guidelines.

7.25.2.6. Provision for internal monitoring and auditing.

7.25.2.7. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

7.25.3. The Contractor shall submit a written copy of its administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse to DSHS for approval, according to Section 7.4, Notices, by March 31st each year of this agreement. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The Contractor shall have thirty (30) calendar days to resubmit the policies and procedures.

7.25.4. The Contractor may request a copy of the guidelines that DSHS will use in evaluating the Contractor's written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, and may request technical assistance in preparing the written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, by contacting the DSHS, MAA, Division of Program Support Contract Manager assigned to the Contractor.

7.26. **Insurance:** The Contractor shall at all times comply with the following insurance requirements.

7.26.1. Commercial General Liability Insurance (CGL): The Contractor shall maintain Commercial General Liability Insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The state of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this contract.

7.26.2. Professional Liability Insurance (PL): If the Contractor provides professional services, either directly or indirectly, the Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

7.26.3. Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and DSHS shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

7.26.4. Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers. In addition, the Contractor shall ensure that all employees and volunteers who use vehicles to transport clients or deliver services have personal automobile insurance and current driver's licenses.

7.26.5. Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to DSHS if requested.

7.26.6. Separation of Insureds: All insurance Commercial General Liability policies shall contain a "separation of insureds" provision.

7.26.7. Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports'' rating of A-, Class VII or better. Any exception must be approved by the DSHS. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

7.26.8. Evidence of Coverage: The Contractor shall submit Certificates of Insurance to DSHS for each coverage required of the Contractor under the Contract no later than March 1, 2005 in accord with the Notices section of this agreement Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

7.26.9. Material Changes: The Contractor shall give DSHS, in accord with the Notices section of this agreement, advance written notice of 45 calendar days of the cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of

premium, the Contractor shall give DSHS advance written notice of 10 calendar days of the cancellation.

7.26.10. General: By requiring insurance, the state of Washington and DSHS do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and DSHS in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

7.26.11. Contractor may waive the requirements contained in 7.26.1, 7.26.2, 7.26.7, and 7.26.8, if self-insured. In the event the Contractor is self insured, the Contractor must send to DSHS by January 15, 2004, a signed written document, which certifies that the contractor is self insured, carries coverage adequate to meet the requirements of section 7.28, will treat DSHS as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for DSHS.

7.27. **No Federal or State Endorsement:** Award of this contract does not indicate endorsement of the Contractor by CMS, the Federal or State government or any similar entity. No federal funds have been used for lobbying purposes in connection with this contract or managed care program.

7.28. **State Conflict of Interest Safeguards:** The State may not contract with a Managed Care Organization unless safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place.

7.29. **Washington Public Disclosure Act:** The Contractor acknowledges that DSHS is subject to the Public Records Act (RCW 42.17). This Contract will be a 'public record' as defined in RCW 42.17. Any documents submitted to DSHS by the Contractor may also be construed as 'public records' and therefore subject to public disclosure under RCW 42.17.

7.30. **Collective Bargaining Agreements:** The Contractor shall comply with all current and future collective bargaining agreements by and between the Governor of the State of Washington and the Service Employees International Union, Local 775, AFL-CIO in accordance with RCW 74.39A.270

8. SUBCONTRACTS

8.1. **Contractor Remains Legally Responsible:** Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this agreement. However, no subcontract shall terminate the Contractor's legal responsibility to DSHS for any work performed under this agreement (42 CFR 434.6 (c)).

8.2. **Solvency Requirements for Subcontractors:** For any subcontractor at financial risk, as described in Section 8.8.3. Substantial Financial Risk or 1.33. Risk, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

8.3. **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

8.3.1. Identification of the parties of the subcontract and their legal basis for operation in the state of Washington.

8.3.2. Procedures and specific criteria for terminating the subcontract.

8.3.3. Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

8.3.4. Reimbursement rates and procedures for services provided under the subcontract.

8.3.5. Release to the Contractor of any information necessary to perform any of its obligations under this agreement.

8.3.6. Reasonable access to facilities and financial and medical records to any authorized agent of the State of Washington or the federal government to monitor, audit and evaluate the Contractor’s compliance with applicable laws, regulations and this agreement.

8.3.7. The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors who are required to report encounter data have the capacity to comply with the Encounter Data Submission Requirements.

8.3.8. The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

8.3.9. No assignment of the subcontract shall take effect without the DSHS' written approval;

8.3.10. The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this agreement, including the applicable requirements of 42 CFR 438.6.

8.3.11. Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this agreement that is applicable to the services to be performed under the subcontract.

8.3.12. The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):

8.3.12.1. The enrollee's right to a fair hearing, how to obtain a hearing and representation rules at a hearing.

8.3.12.2. The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

8.3.12.3. The availability of assistance in filing grievances and appeals.

8.3.12.4. The toll-free numbers to file oral grievances and appeals.

8.3.12.5. The enrollee's right to request continuation of benefits during an appeal or fair hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits.

8.3.13. All subcontracts shall contain a provision under which DSHS shall the right to request and receive any documents from the subcontractor that DSHS deems necessary and appropriate in connection with this contract.

8.4. **Health Care Provider Subcontracts**, including those for facilities, shall also contain the following provisions:

8.4.1. A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this agreement.

8.4.2. A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality

Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Re-credentialing.

8.4.2.1. Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

8.4.2.1.1. Assigned responsibilities;

8.4.2.1.2. Delegated activities;

8.4.2.1.3. A mechanism for evaluation;

8.4.2.1.4. Corrective action policy.

8.4.3. Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

8.4.4. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from DSHS or any enrollee for covered services performed under the subcontract.

8.4.5. The subcontractor agrees to hold harmless DSHS and its employees, and all enrollees served under the terms of this agreement in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

8.4.6. If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this agreement.

8.4.7. A ninety (90) day termination notice provision.

8.4.8. A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

8.4.9. The subcontractor agrees to comply with the appointment wait time standards of this agreement. The subcontract must provide for regular monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 CFR 438.206(c)(1).

8.4.10. A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 CFR 438.230(b)).

8.5. **Health Care Provider Subcontracts Delegating Administrative Functions:** Subcontracts that delegate administrative functions under the terms of this agreement shall include the following additional provisions:

8.5.1. For those subcontractors at financial risk, that the subcontractor shall maintain the same solvency requirements as apply to the Contractor throughout the term of the subcontract.

8.5.2. Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but not limited to utilization/ medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this agreement.

8.5.3. How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

8.5.4. Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

8.5.5. A non-discrimination process;

8.5.6. A process to ensure credentialing and re-credentialing confidentiality; and

8.5.7. A process for credentialing and re-credentialing decisions.

8.6. **Excluded Providers:**

8.6.1. Pursuant to Section 1128 of the Social Security Act, the Contractor may not subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been: convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare and Medicaid program, assessed a civil penalty under the provisions of Section 1128, has a contractual relationship with an entity convicted of a crime specified in Section 1128, or is a person described in Section 7.26 of this agreement, Excluded Persons.

8.6.2. In addition, if DSHS terminates a subcontractor from participation in any DSHS program, the Contractor shall exclude the subcontractor from participation in MMIP. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier.

8.7. **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this agreement, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. The Department will provide a current list of bonded home health agencies upon request to the Contractor.

8.8. **Physician Incentive Plans:** Physician incentive plans, as defined herein, are subject to the conditions set forth in this section in accord with federal regulations (42 CFR 422.208 and 42 CFR 422.210).

8.8.1. **Prohibited Payments:** The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

8.8.2. **Disclosure Requirements:** Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by DSHS. The Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of all its subcontractors in any tier, to the Department annually upon request:

8.8.2.1. Whether the incentive plan includes referral services.

8.8.2.2. If the incentive plan includes referral services:

8.8.2.2.1. The type of incentive plan (e.g. withhold, bonus, capitation)

8.8.2.2.2. For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

8.8.2.2.3. Proof that stop-loss protection meets the requirements of 8.8.4.1., including the amount and type of stop-loss protection.

8.8.2.2.4. The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military and Basic Health Plan members.

8.8.3. **Substantial Financial Risk:** A physician or physician group as defined herein, is at substantial financial risk when more than 25% of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 members arrangements that cause substantial financial risk include, but are not limited to, the following:

8.8.3.1. Withholds greater than 25% of total potential payments

8.8.3.2. Withholds less than 25% of total potential payments but the physician or physician group is potentially liable for more than 25% of total potential payments.

8.8.3.3. Bonuses greater than 33% of total potential payments, less the bonus.

8.8.3.4. Withholds plus bonuses if the withholds plus bonuses equal more than 25% of total potential payments.

8.8.3.5. Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25% of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the contract.

8.8.4. **Requirements if a Physician or Physician Group is at Substantial Financial Risk:** If the Contractor, or any subcontractor (e.g. IPA, PHO), places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

8.8.4.1. If aggregate stop-loss protection is provided, it must cover 90% of the costs of referral services that exceed 25% of maximum potential payments under the subcontract.

8.8.4.2. If stop-loss protection is based on a per-member limit, it must cover 90% of the cost of referral services that exceed the limit as

indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

8.8.4.2.1. 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

8.8.4.2.2. 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

8.8.4.2.3. 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

8.8.4.2.4. 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

8.8.4.2.5. 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

8.8.4.2.6. 25,001 members or more, there is no risk threshold.

8.8.4.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement and waive the requirement for the Contractor to conduct such surveys. DSHS shall notify the Contractor in writing if the requirement is waived. If DSHS does not waive the requirement, the Contractor shall provide the survey results to DSHS annually upon request. The surveys shall:

8.8.4.3.1. Include current enrollees, and enrollees who have disenrolled within 12 months of the survey for reasons other than loss of Medicaid eligibility or moving outside the Contractor's service area.

8.8.4.3.2. Be conducted according to commonly accepted principles of survey design and statistical analysis.

8.8.4.3.3. Address enrollees satisfaction with the physician or physician group's:

8.8.4.3.3.1. Quality of services provided.

8.8.4.3.3.2. Degree of access to services.

8.8.4.4. Provide survey results to enrollees upon request by the enrollee.

8.8.5. **Sanctions and Penalties:** DSHS or CMS may impose intermediate sanctions, as described in Section 7.7 of this agreement, for failure to comply with the rules in this section.

8.9. **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

9. TERM AND TERMINATION

9.1. **Term:** This agreement is effective from June 1, 2005 at 12:01 a.m. Pacific Standard Time (PST) through 11:59 p.m. on December 31, 2006, PST. This agreement may be extended by mutual agreement of the parties.

9.2. **Termination for Convenience:**

9.2.1. Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this agreement in whole or in part, whenever, for any reason, either party shall determine that such termination is in its best interest.

9.2.2. In the event DSHS terminates this agreement for convenience, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs. Such claim must be:

9.2.2.1. Delivered to DSHS as provided in Section 7.4., Notices.

9.2.2.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of Section 9.4, Termination by DSHS for Default, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this Section. DSHS may extend said ninety (90) calendar days if the Contractor makes a written request to DSHS and DSHS deems the grounds for the request to be reasonable. The DSHS will evaluate the claim for termination costs and order DSHS to pay the claim or such amount, as s/he deems valid, or deny the claim. The DSHS shall

notify the Contractor of DSHS' decision within sixty (60) calendar days of receipt of the claim.

9.2.3. In the event the Contractor terminates this agreement for convenience, DSHS shall have the right to assert a claim for DSHS' direct termination costs. Such claim must be:

9.2.3.1. Delivered to the Contractor as provided in Section 7.4., Notices.

9.2.3.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The Contractor may extend said ninety (90) calendar days if DSHS makes a written request to the Contractor and the Contractor deems the grounds for the request to be reasonable.

9.2.3.3. The Contractor shall pay the claim for termination costs submitted by DSHS.

9.2.4. In the event the Contractor or DSHS disagrees with the decision entered pursuant to this Section, the Contractor or DSHS shall have the right to a dispute resolution as described in Section 7.21, Disputes.

9.2.5. In no event shall the claim for termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.

9.2.6. In addition to DSHS' or Contractor's direct termination costs, the Contractor or DSHS shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.

9.2.7. The Contractor or DSHS shall not be liable for any termination costs if it notifies the other party of its intent not to renew this agreement at least one hundred twenty (120) calendar days prior to the renewal date.

9.2.8. In the event this agreement is terminated for the convenience of either party, the effective date of termination shall be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.

9.3. **Termination by the Contractor for Default:** The Contractor may terminate this agreement whenever DSHS shall default in performance of this agreement and shall fail to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may

allow) after receipt from the Contractor of a written notice specifying the default. For purposes of this section, default shall mean failure to meet one or more material obligations of this agreement. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination through the dispute resolution provisions of this agreement or by a court of competent jurisdiction. The procedure for determining damages shall be as stated in Section 9.2.

9.4. **Termination by DSHS for Default**: The Contract Administrator may terminate this agreement whenever the Contractor shall default in performance of this agreement and fails to cure such default within a period of one hundred twenty (120) calendar days (or such longer period as the Contracts Administrator may allow) after receipt from the Contracts Administrator of a written notice specifying the default. Such termination shall be referred to herein as "Termination for Default."

9.4.1. If after notice of termination of this agreement for default it is determined by DSHS or a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without the error or negligence of the Contractor, or any subcontractor, the Contractor may claim damages. The procedure for determining damages shall be as described in Section 9.2.

9.4.2. In the event DSHS terminates this Contract as provided above, DSHS may procure, upon such terms and in such manner as the Contracts Administrator may deem appropriate, supplies or services similar to those terminated, and if the Contractor is judged to be in default by a court of law, DSHS damages shall be measured by any excess costs for such similar supplies or services. In addition, DSHS' damages may also include reasonable administrative costs incurred in procuring such similar supplies or services.

9.5. **Mandatory Termination**: DSHS shall terminate this agreement in the event that the Secretary of the Department of Health and Human Services determines that the Contractor does not meet the requirements for participation in the Medicaid program pursuant to federal law.

9.5.1. In addition, DSHS is required under federal law to either impose temporary management or terminate this agreement if the Contractor is repeatedly found to not meet federal requirements for Managed Care Organizations, as specified in Section 1903(m) of the Social Security Act. Should this circumstance arise, DSHS shall terminate this agreement consistent with Section 9.4, Termination by DSHS for Default.

9.6. **Termination Due to Change in Funding**: If the funds DSHS relied upon to establish this agreement are withdrawn or reduce, or if additional or modified conditions are place on such funding, DSHS may immediately terminate this agreement by providing written notice to the Contractor. The termination shall be effective on the date specified in the termination notice.

9.7. **Information on Outstanding Claims at Termination**: In the event this agreement is terminated, the Contractor shall provide DSHS, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of Section 3, Payment.

9.8. **Continued Responsibilities**: After the termination of this agreement, the Contractor remains obligated to:

9.8.1. Cover hospitalized enrollees until discharge consistent with Section 3.5;

9.8.2. Submit reports required in Section 6;

9.8.3. Provide access to records are required in Section 7.13;

9.8.4. Provide the administrative services associated with covered services (e.g. claims processing, enrollee appeals) provided to enrollees under the terms of this agreement.

9.8.5. Cover pre-paid nursing facility stays in accordance with the terms of Exhibit B, Rates and Payment.

9.9. **Enrollee Notice of Termination**: DSHS shall inform enrollees when notice is given by either party of its intent to terminate this agreement as provided herein.

9.10. **Pre-termination Dispute Resolution**: If the Contractor disagrees with a DSHS decision to terminate this agreement, other than a termination for convenience, the Contractor will have the right to a dispute resolution as described in Section 7.21, Disputes.

9.11. **Pre-termination Hearing and Procedures**: If the dispute process is not successful, DSHS shall provide the Contract a pre-termination hearing prior to termination of the agreement under 42 CFR 438.708. DSHS shall:

9.11.1. Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

9.11.2. Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this agreement, and, for an affirming decision, the effective date of termination; and

9.11.3. For an affirming decision, give enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

10. SERVICE DELIVERY

10.1. **Scope of Services:** The Contractor shall cover enrollees for preventive care, diagnosis and treatment of illness and injury and long-term care, as set forth in Section 11, Schedule of Benefits. If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program as described in DSHS' billing instructions, the Contractor shall cover it subject to the specific exclusions and limitations in Section 11, Schedule of Benefits. Except as otherwise specifically provided in this agreement, the Contractor shall provide covered services in the amount, duration and scope described in the Medicaid State Plan and all its amendments.

Except as specifically provided in Section 10.17, this shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary covered services to enrollees. The Contractor may limit coverage of services to participating providers except as specifically provided in Section 4, Access and Capacity, Section 11, Schedule of Benefits, for emergency services, and as necessary to provide medically necessary services as described in this section.

The contractor is responsible for covering services relating to the prevention, diagnosis, and treatment of health impairments, when those services are medically necessary and within the scope of the enrollee's medical assistance program. The Contractor is also responsible for covering services relating to the enrollee's ability to achieve age-appropriate growth and development, when those services are medically necessary and within the scope of the enrollee's medical assistance program. Finally, the Contractor is responsible for covering services relating to the client's ability to attain, maintain, or regain functional capacity, when those services are medically necessary and within the scope of the enrollee's medical assistance program.

10.1.1. **In Service Area:** The Contractor shall cover MMIP enrollees in for all medically necessary services included in the scope of services covered by this agreement.

10.2. **Out of Service Area:** The Contractor shall cover emergency, post-stabilization and non-emergency services, which are medically necessary and cannot reasonably wait until the enrollee's return to the service area, for enrollees temporarily outside of the service area or who have moved to another service area but are still enrolled with the Contractor. The Contractor may require pre-authorization for non-emergency services as long as the wait times specified in Section 4.6, 4.7, and 4.8 are not exceeded. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area.

10.2.1.1. When the Contractor confirms that an enrollee has permanently moved out of the service area; the Contractor may request disenrollment of the enrollee within 30 days of notification. The Contractor shall cover emergency, post-stabilization and urgent care for enrollees who have permanently moved out of the service area for 30 calendar days.

10.2.1.2. When an enrollee is temporarily outside the service area, coverage shall be limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee leaves the service area. The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America.

10.3. **Medical Necessity Determination:** The Contractor shall determine which services are medically necessary, according to utilization management requirements Quality Improvement Program Standards in Exhibit A and according to the definition of Medically Necessary Services in this agreement. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this agreement regarding appeals, fair hearings and independent review.

10.4. **Enrollee Choice of PCP**: The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP. If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity tot the enrollee’s home, no later than fifteen (15) working days after coverage begins. The Contractor shall allow an enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the enrollee’s request for the change. (WAC 388-538-060 and WAC 284-43-251(1)).

10.4.1. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this agreement demonstrates a need for a

course of treatment or regular monitoring by such specialist (42 CFR 438.208).

10.5. **Continuity of Care**: The Contract shall ensure the Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted.

10.5.1. For changes in the Contractor's provider network or service areas, the Contractor shall comply with the provisions of Sections 4.13.

10.5.2. If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

10.5.3. Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

10.5.4. The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment for the lesser of:

10.5.4.1. 30 calendar days after enrollment with the Contractor;

10.5.4.2. Prescription expiration; or

10.5.4.3. A participating provider performs an examination of the enrollee to evaluate the need for the prescription.

10.6. **Second Opinions**: The Contractor must provide for a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or arrange for the enrollee to obtain one outside the Contractor's network, at no cost to the enrollee.

This section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

10.7. **Enrollee Self-Determination**: The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 & 42 CFR 438.6); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

10.8. **Compliance with Federal Regulations for Sterilizations and Hysterectomies:** The Contractor shall assure that all sterilizations and hysterectomies performed under this agreement are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is obtained from the enrollee prior to such procedure.

10.9. **Program Information:** At the Contractor's request, DSHS shall provide the Contractor with pertinent documents including statutes, regulations, and current versions of billing instructions and other written documents which describe DSHS policies and guidelines related to service coverage and reimbursement.

10.10. **Confidentiality of Enrollee Information:** The Contractor shall comply with all state and federal laws and regulations concerning the confidentiality of enrollee information.

10.10.1. The use or disclosure of any information concerning an enrollee, including but not limited to medical records, by the Contractor and its subcontractors for any purpose not directly connected with the provision of services under this agreement is prohibited, except by written consent of the enrollee, his/her representative, or his/her responsible parent or guardian, or as otherwise provided by law.

10.10.2. The Contractor and DSHS agree to share information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to HIPAA, the HIPAA regulations, 42 CFR 431 Subpart F, RCW 5.60.060(4), and RCW 70.02).

10.10.3. Retained client data shared by DSHS with the Contractor, due to the confidentiality of the information must be maintained throughout the life cycle of the data, to include any record retention cycle, or archival period, in a manner that will retain its confidential nature regardless of the age or media format of the data.

10.11. **Marketing:** The Contractor, and any subcontractors through which the Contractor provides covered services, shall comply with the following requirements regarding marketing:

10.11.1. All marketing materials must be reviewed by and have the prior written approval of DSHS.

10.11.2. Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

10.11.3. Marketing materials must be distributed in all service areas the Contractor serves.

10.11.4. Marketing materials must be in compliance with Section 4.10., Equal Access for Enrollees and Potential Enrollees with Communication Barriers. Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials in accord with contract Section 4.10.2. DSHS may determine, in its sole judgment, if materials that are primarily visual meet the requirements of contract Section 4.10.

10.11.5. The Contractor shall not offer anything of value as an inducement to enrollment.

10.11.6. The Contractor shall not use the sale of other insurance to attempt to influence enrollment.

10.11.7. The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

10.12. **Information Requirements for Enrollees and Potential Enrollees:** The Contractor shall provide sufficient, accurate oral and written information to potential enrollees to assist them in making an informed decision about enrollment (SSA 1932(d)(2) and 42 CFR 438.10). The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care. All enrollee information shall have the prior written approval of DSHS. Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of DSHS, the change is significant in regard to the enrollees' quality of or access to care.

The Contractor's written information to enrollees and potential enrollees shall include:

10.12.1. How to choose a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

10.12.2. How to access Emergency Department Care.

10.12.3. General information about accessing hospital care and how to get a list of hospitals that are available to enrollees.

10.12.4. General information regarding specialists available to enrollees and how to obtain specific information including a list of specialists that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

10.12.5. How to obtain information regarding any limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP.

10.12.6. How to obtain information regarding Physician Incentive Plans (42 CFR 422.210(b)), and information on the Contractor's structure and operations.

10.12.7. How to change a PCP.

10.12.8. Informed consent guidelines.

10.12.9. Information regarding conversion rights under RCW 48.46.450 or RCW 48.44.370.

10.12.10. How to request a disenrollment.

10.12.11. The following information regarding advance directives:

10.12.11.1. A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.

10.12.11.2. The written policies and procedures of the Contractor concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive.

10.12.11.3. An enrollee's rights under state law.

10.12.12. How to recommend changes in the Contractor's policies and procedures.

10.12.13. Health promotion, health education and preventive health services available.

10.12.14. How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential except as needed to process the grievance, appeal or independent review.

10.12.15. The right to initiate a grievance or file an appeal, in accordance with the Contractor's DSHS approved policies and procedures regarding grievances and appeals.

10.12.16. The right to request a DSHS Fair Hearing after the Contractor's appeal process is exhausted, how to request a DSHS Fair Hearing and the rules that govern representation at the Fair Hearing.

10.12.17. The right to request an independent review in accord with RCW 48.43.535 and WAC 246-305 after the DSHS Fair Hearing process is exhausted and how to request an independent review.

10.12.18. The right to appeal an independent review decision to the DSHS Board of Appeals and how to request such an appeal.

10.12.19. Requirements and timelines for grievances, appeals, fair hearings, independent review and Board of Appeals.

10.12.20. Rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or fair hearing.

10.12.21. Availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.

10.12.22. The enrollee's rights and responsibilities with respect to receiving covered services.

10.12.23. Information about covered benefits and how to contract DSHS regarding services that may be covered by DSHS, but are not covered benefits under this agreement.

10.12.24. Information regarding the availability of and how to access or obtain interpretation services and translation of written information.

10.12.25. How to obtain information in alternative formats.

10.12.26. The enrollee's right to and procedure for obtaining a second opinion.

10.12.27. The prohibition on charging enrollees for covered services.

10.13. **Prohibition on Enrollee Charges for Covered Services:** Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services (SSA 1932(b)(6), SSA 1128B(d)(1)).

10.14. **Provider/Enrollee Communication:** The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following (42 CFR 438.102(a)(1)):

10.14.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

10.14.2. Any information the enrollee needs in order to decide among all relevant treatment options.

10.14.3. The risks, benefits, and consequences of treatment or non-treatment.

10.14.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

10.15. **Provider Nondiscrimination:**

10.15.1. The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely based on the type of license or certification they hold.

10.15.2. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

10.15.3. The Contractor’s provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).

10.15.4. This section may not be construed to require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees; preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

10.16. **Experimental and Investigational Services:**

10.16.1. If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed to be experimental or investigational, the Contractor shall develop and follow policies and procedures for such exclusions and

limitations. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to DSHS upon request.

In making the determination, whether a service is experimental and investigational and, therefore, not a covered service, the Contractor shall consider the following:

10.16.1.1. Evidence in peer-reviewed, medical literature, as defined herein, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications.

10.16.1.2. Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

10.16.1.3. Any relevant, specific aspects of the condition.

10.16.1.4. Whether the service or treatment is generally used for the condition in the state of Washington.

10.16.1.5. Whether the service or treatment is under continuing scientific testing and research.

10.16.1.6. Whether the service or treatment shows a demonstrable benefit for the condition.

10.16.1.7. Whether the service or treatment is safe and efficacious.

10.16.1.8. Whether the service or treatment will result in greater benefits for the condition than another generally available service.

10.16.1.9. If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

10.16.2. Criteria to determine whether a service is experimental or investigational shall be no more stringent for MMIP enrollees than that applied to any other enrollees. A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

10.16.3. A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

10.16.4. A determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, including independent review, through the DSHS fair hearing process and independent review under WAC 246-305.

10.17. **Enrollee Rights and Protections:**

10.17.1. The Contractor shall have written policies regarding enrollee rights (42 CFR 438.100(a)(1)).

10.17.2. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2).

10.17.3. The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):

10.17.3.1. To be treated with respect and with consideration for their dignity and privacy.

10.17.3.2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s ability to understand.

10.17.3.3. To participate in decisions regarding their health care, including the right to refuse treatment.

10.17.3.4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

10.17.3.5. To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.

10.17.3.6. Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 CFR 438.100(c)).

10.18. **Authorization of Services:** In regard to the authorization of services for enrollees, the Contractor shall have in place policies and procedures, and shall require that subcontractors with delegated authority for authorization to comply with such policies and procedures, that comply with 42 CFR 438.210, WAC 388-538 and the provisions of this agreement. The policies and procedures must include a definition of service authorization that includes the enrollee's initial request for a service.

10.18.1. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

10.18.2. The Contractor shall consult with the requesting provider when appropriate.

10.18.3. The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

10.18.4. The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements, except that the notice to the provider need not be in writing (42 CFR 438.404):

10.18.4.1. The notice to the enrollee shall be in writing and shall meet the requirements of Section 4.10.2 of this agreement to ensure ease of understanding.

10.18.4.2. The notice shall explain the following:

10.18.4.2.1. The action the Contractor has taken or intends to take.

10.18.4.2.2. The reasons for the action.

10.18.4.2.3. The enrollee's right to file an appeal.

10.18.4.2.4. The procedures for exercising the enrollee's rights.

10.18.4.2.5. The circumstances under which expedited resolution is available and how to request it.

10.18.4.2.6. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be

continued, and the circumstances under which the enrollee may be required to pay for these services.

10.18.5. The Contractor shall provide for the following timeframes for authorization decisions and notices:

10.18.5.1. For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

10.18.5.2. For termination, suspension, or reduction or previously authorized services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within the ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

10.18.5.3. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days under the following circumstances:

10.18.5.3.1. The enrollee or the provider requests extension; or

10.18.5.3.2. The Contractor justifies and documents a need for added information and how the extension is in the enrollee's interest.

10.18.5.3.3. If the Contractor extends that timeframe, it shall:

10.18.5.3.3.1. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decisions; and

10.18.5.3.3.2. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

10.18.5.4. For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the

request for service. The Contractor may extend the three (3) working days by up to 14 calendar days under the following circumstances;

10.18.5.4.1. The enrollee, or the provider, requests extension; or

10.18.5.4.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10.18.6. If the Contractor fails to comply with the timeframes in this Section, the Contractor shall cover the services that are the subject of the authorization.

10.19. **Grievance System:** The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F, WAC 388-538 and, insofar as it is not in conflict with 42 CFR 438 Subpart F or WAC 388-538, or WAC 284-43 Subpart F. The grievance system shall include a grievance process, an appeal process and access to the DSHS fair hearing process.

10.19.1. The Contractor shall submit policies and procedures addressing the grievance system that comply with the requirements of this agreement to the DSHS, ADSA Contract Manager assigned to the Contractor by March 1, 2005 and upon change thereafter. The Contractor shall include copies of all related notices to enrollees. DSHS must approve, in writing, all policies and procedures regarding the grievance system. The grievance system requirements in this agreement shall be in place by May 1, 2005.

10.19.2. The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals.

10.19.3. The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days.

10.19.4. The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making.

10.19.5. Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

10.19.5.1. If the enrollee is appealing an action concerning medical necessity.

10.19.5.2. If an enrollee grievance concerns a denial of expedited resolution of an appeal.

10.19.5.3. If the grievance or appeal involves any clinical issues.

10.19.6. **Grievance Process**: The following requirements are specific to the grievance:

10.19.6.1. Only an enrollee may file a grievance with the Contractor, a provider may not file a grievance on behalf of an enrollee.

10.19.6.2. Enrollees may file a grievance orally or in writing;

10.19.6.3. The Contractor shall complete the disposition of a grievance and notice to the affected parities within ninety (90) calendar days of receiving the grievance.

10.19.6.4. The Contractor may notify enrollees of the disposition of grievances orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

10.19.6.5. Enrollees do not have the right to a fair hearing in regard to the disposition of a grievance.

10.19.7. **Appeal Process**: The following requirements are specific to the appeal process:

10.19.7.1. If the Contractor fails to meet the timeframes in this Section concerning any appeal, including timely notice of actions, the Contractor shall cover the services that are the subject of the appeal;

10.19.7.2. An enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action.

10.19.7.3. For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal.

10.19.7.4. For appeals for termination, suspension, or reduction of previously authorized services when the enrollee request continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is

not obligated to continue services and the timeframes for appeals for standard service authorization apply.

10.19.7.5. Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution.

10.19.7.6. The appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the enrollee of the limited time available for this in the case of expedited resolution.

10.19.7.7. The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process.

10.19.7.8. The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

10.19.7.9. The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health conditions requires, within the following timeframes:

10.19.7.9.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services and notice to the affected parties; no longer than forty-five (45) calendar days from the day the Contractor receives the appeal. This timeframe may not be extended.

10.19.7.9.2. For expedited resolution or appeals, including notice to the affect parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

10.19.7.10. The notice of the resolution of the appeal shall:

10.19.7.10.1. Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

10.19.7.10.2. Include the results of the resolution process and the date it was completed.

10.19.7.10.3. For appeals not resolved wholly in favor of the enrollee:

10.19.7.10.3.1. Include information on the enrollee's right to request a DSHS fair hearing and how to do so.

10.19.7.10.3.2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

10.19.7.10.3.3. Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

10.19.8. **Expedited Appeal Process:**

10.19.8.1. The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.

10.19.8.2. The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.

10.19.8.3. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

10.19.9. **Fair Hearing:**

10.19.9.1. A provider may not request a state fair hearing on behalf of an enrollee.

10.19.9.2. The parties to the State Fair Hearing include DSHS, the Contractor and the enrollee and his or her representative, or the representative of a deceased enrollee's estate.

10.19.9.3. If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a DSHS fair hearing within the following time frames (see (WAC 388-538-112 for the fair hearing process for enrollees):

10.19.9.3.1. For appeals regarding a standard service, within ninety (90) calendar days of the data on the Contractor's mailing of the notice of the resolution of the appeal.

10.19.9.3.2. For appeals regarding termination, suspension, or reduction of a previously authorized service, if the enrollee request continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard service authorization apply.

10.19.9.4. If the enrollee requests a fair hearing, the Contractor shall provide to DSHS upon request, and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records or written decision(s) from participating providers or delegated entities.

10.19.9.5. The Contractor will have the opportunity to present its position at the fair hearing.

10.19.9.6. The Contractor's medical director or designee shall review all cases where a fair hearing is requested and any related appeals, when medical necessity is an issue.

10.19.9.7. The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a fair hearing with DSHS.

10.19.9.8. DSHS will notify the Contractor of fair hearing determinations. The Contractor will be bound by the fair hearing determination, whether or not the fair hearing determination upholds the Contractor's decision. Implementation of such fair hearing decision shall not be the basis for disenrollment of the enrollee by the Contractor.

10.19.9.9. If the fair hearing decision is not within the purview of this agreement, then DSHS will be responsible for the implementation of the fair hearing decision.

10.19.10. **Expedited Fair Hearing**: The state must reach a decision on an expedited request if the appeal was heard first through the Contractor's appeal process: within three (3) working days from DSHS receipt of a hearing request for a denial of a service that:

10.19.10.1. Meets the criteria for an expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

10.19.10.2. Was resolved wholly or partially adversely to the enrollee using the Contractor's expedited appeal timeframes.

10.20. **Independent Review**: After exhausting both the Contractor's appeal process and the fair hearing process an enrollee has a right to independent review in accord with RCW 48.43.434 and WAC 284-483-630.

10.20.1. An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the DSHS Board of Appeals in accord with WAC 388-02-560 through 388-02-590. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.

10.21. **Continuation of Services**:

10.21.1. The Contractor shall continue the enrollee's services if all of the following apply:

10.21.1.1. The enrollee or the provider files for an appeal, fair hearing or independent review on or before the later of the following:

10.21.1.1.1. Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

10.21.1.1.2. The intended effective date of the Contractor's proposed action.

10.21.1.2. The appeal involves the termination, suspension, or reduction or a previously authorized course of treatment.

10.21.1.3. The services were ordered by an authorized provider.

10.21.1.4. The original period covered by the original authorization has not expired.

10.21.1.5. The enrollee requests an extension of services.

10.21.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, fair hearing, independent review or DSHS Board of Appeals is pending, the services shall be continued until one of the following occurs:

10.21.2.1. The enrollee withdraws the appeal, fair hearing or independent review request.

10.21.2.2. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a state fair hearing (with continuation of services until the state fair hearing decision is reached) within ten (10) calendar days.

10.21.2.3. Ten (10) calendar days pass after DSHS mails the notice of resolution of the sate fair hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

10.21.2.4. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollee has not requested a DSHS Board of Appeals (with the continuation of services until the DSHS Board of Appeals decision is reached) within ten (10) calendar days.

10.21.2.5. The time period or service limit of a previously authorized service has been met.

10.21.3. If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

10.22. **Effect of Reversed Resolutions of Appeals and Fair Hearings:**

10.22.1. If the Contractor, the Office of Administrative Hearings (OAH), the independent review organization (IRO) or the DSHS Board of Appeals

reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires

10.22.2. If the Contractor, OAH, IRO, or DSHS Board of Appeals reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services.

11. SCHEDULE OF BENEFITS

11.1. Covered Services:

11.1.1. The Contractor shall cover the services described in this section when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition. The Contractor shall ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished, and shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition.

11.1.2. Except as specifically provided herein, the scope of covered services shall be comparable to the DSHS Medicaid fee-for-service program, including long-term care services provided by ADSA. For specific covered services, this shall not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

11.2. **Care Coordination:** The Contractor shall provide Care Coordination services that ensure access to and integration of preventive, primary, acute, post acute, rehabilitation, and long- term care services into a system that appears seamless to the enrollee. In addition to coordinating the services covered by the MMIP, the Contractor shall coordinate the services it provides to its enrollees with the services an enrollee receives from other care systems.

11.2.1. The Contractor shall provide a Care Coordination system designed to:

11.2.1.1. Ensure communication and coordination of an enrollee's care across network provider types and settings; and

11.2.1.2. Ensure smooth transitions for enrollees who move among various care settings;

11.2.2. The Care Coordination system shall provide each enrollee with a primary contact person who will assist the enrollee in accessing services and information. The system shall promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability.

The Contractor shall designate a care coordinator and/or nurse practitioner to provide an initial screening and needs assessment that forms the basis for a comprehensive care plan, and for developing and implementing the care plan. The care coordinator shall have responsibilities as follows:

11.2.2.1. Provide an initial screening for all enrollees, to assign risk level and determine the enrollee's need for services. The initial screening shall take place within thirty (30) days of enrollment. If the Contractor is unable to conduct the initial screening within 30 days, the Contractor shall document efforts to conduct the screening.

11.2.2.1.1. The initial screening shall include a screening for dementia using a Department-approved dementia screening tool. The Contractor shall track the numbers of enrollees who screened positive for dementia and the steps taken once an enrollee was found with a positive dementia screen.

11.2.2.1.2. Provide a comprehensive assessment for clients who have been determined, by claims data, and/or through the initial screening, to be high risk, or who have been identified as having special health care needs by DSHS or through the screening process. The Contractor shall also ensure periodic reassessment as necessary, of supports and services, based on the Enrollee's strengths, needs, choices and preferences for care.

The Contractor shall ensure that the initial assessment takes place within thirty (30) days of the initial screening, will include medical, social and environmental, mental health, long-term-care, and chemical dependency factors, and will determine whether the enrollee should be referred for specific services. The assessment will also identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The Contractor shall coordinate their assessment with required assessments done by DSHS staff. The Contractor's assessment shall be based on medical necessity and take into account the client's goals and preferences. The

Contractor shall offer at least the number of personal care hours authorized by DSHS' assessment unless the enrollee chooses an alternative proposed by the Contractor. The enrollee's choice must be documented in writing in the enrollee's file and must include the enrollee's signature.

If the enrollee is determined to need services not covered by this contract, the Contractor shall ensure coordination of the referral to the appropriate service. If the service is covered by DSHS on a fee for service basis, the Contractor shall coordinate with appropriate service providers to ensure the enrollee receives the needed service. The Contractor shall coordinate this assessment with required assessments done by DSHS staff. If the Contractor is unable to conduct the screening, the Contractor shall document efforts to do so in the enrollee's file.

11.2.2.2. Develop a comprehensive care plan based on medical necessity, issues or needs identified by the initial assessment, medical records and/or prior utilization data to the extent they are available, enrollee and/or family input, and PCP input if the enrollee has a PCP. If the enrollee does not have a PCP, the Contractor shall assist the enrollee in finding one. The care plan shall incorporate an interdisciplinary/holistic and preventive focus, address any barriers to care, accommodate the specific cultural and linguistic needs of the enrollee, and include advance directive planning and enrollee participation. The Contractor shall ensure that the enrollee's plan is updated based on ongoing assessment or information received by a DSHS case manager, one of the enrollee's providers, or other collateral contacts.

11.2.2.3. Have authority to approve referrals and requests for services and equipment within the care plan;

11.2.2.4. Provide the enrollee with information about advance directives, and assist the enrollee in advance directive planning, if the enrollee requests, based on enrollee needs and cultural considerations. The Contractor shall initiate discussion with the enrollee and/or the enrollee's family or guardian when the lack of a documented advance directive is identified through the assessment process. The advance directive or a record of the enrollee's refusal of assistance shall be kept on file in the enrollee's case management record.

11.2.2.5. Arrange and coordinate the provision of supports and services identified in the enrollee's care plan, including early intervention

services and preventive care, skilled specialty services and, community-based services.

11.2.2.6. Assist the enrollee and his or her family or legal representatives, if any, to maximize informed choices of services and control over services and supports.

11.2.2.7. Monitor the enrollee's progress toward achieving the outcomes identified in the enrollee's care plan on a regular basis, in order to evaluate and adjust the timeliness and adequacy of services.

11.2.2.8. Coordinate with DSHS and local agency case managers, financial workers and other staff.

11.2.2.9. Communicate on an ongoing basis with the enrollee and with other individuals participating in the enrollee's care plan.

11.2.2.10. Educate and communicate with the enrollee about good health care practices and behaviors.

11.2.2.11. Have knowledge of basic enrollee protection requirements, including data privacy.

11.2.2.12. Inform, educate, and assist the enrollee in identifying available service providers and accessing needed resources and services, including those that are beyond the limitations of this agreement.

11.2.3. The Contractor shall develop written protocols for:

11.2.3.1. Tracking referrals.

11.2.3.2. Providing or arranging for second opinions, whether in or out of network.

11.2.3.3. Sharing clinical information, including updates on the enrollee's care plan with other entities serving the enrollee, including when appropriate, the contractor's identification and assessment of enrollees with special health care needs, so that services provided to enrollees will not be duplicated.

11.2.3.4. Tracking and coordination of enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult day health) and ensuring continuity of care.

11.2.4. The Contractor shall monitor the continuity and coordination of care, using results of monitoring to improve continuity and coordination across the network. Monitoring activities shall include :

11.2.4.1. Annual collection of coordination data;

11.2.4.2. Identification of opportunities for improvement using quantitative and causal analysis;

11.2.4.3. Selection of opportunities for improvement using coordination data.

11.3. **Disease Management:** The Contractor shall provide a program designed to assist enrollees with chronic illness, including: Diabetes, Asthma, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease (ESRD) to work towards the following goals:

11.3.1. Increase the enrollee's (and/or their caregiver's) understanding of their disease so they are:

11.3.1.1. More effective partners in the care of their disease;

11.3.1.2. Better able to understand the appropriate use of resources needed to care for their disease(s);

11.3.1.3. Able to identify when they are getting in trouble earlier and seek appropriate attention before they reach crisis levels; and

11.3.1.4. More compliant with medical recommendations.

11.3.2. Improve the enrollee's quality of life by assisting him or her in "self-management" of their disease and in accessing regular preventive health care.

11.4. **Long-Term Care Services**: The Contractor shall provide long-term care services including:

11.4.1. **Adult Day Care:** Adult day care is a supervised daytime program for adults with medical or disabling conditions that do not require the level of care provided by a registered nurse or licensed rehabilitative therapist. Services include personal care, social services and activities, education, routine health monitoring, general therapeutic activities, a nutritious meal and snacks, supervision and/or protection for adults who require it, coordination of transportation, and first aid and emergency care.

11.4.2. **Adult Day Health**: Adult day health is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition

to adult day care. An adult day health center provides skilled nursing services, rehabilitative therapy such as physical therapy, occupational therapy or speech-language therapy and brief psychological and/or counseling services and all of the services listed for adult day care above.

11.4.3. **Environmental Modifications/Assistive Technology**: Physical adaptations, including things like installing ramps, grab-bars, widening doorways, , modifying bathrooms, or installing special systems to accommodate medical equipment are made in the home. Assistive Technology includes any item, piece of equipment, or product system whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain, or improve the functional capabilities of a client.

11.4.4. **Health Screening:** Preventive health measures are provided including a general health assessment, limited physical examination, and selected laboratory tests.

11.4.5. **Home Health Care:** In-home health care (monitoring, treatment, therapies, medications, exercises) is authorized by a physician and provided by nurses, therapists, or trained aides.

11.4.6. **Minor Household Repairs:** Home or apartment repairs/modifications made to maintain the enrollee's health and safety.

11.4.7. **Nurse Delegation:** Training and supervision of a nursing assistant to do routine health care tasks by a registered nurse. The trained nursing assistant shall provide care in the enrollee's home setting. The nursing assistant shall only perform those tasks allow in rule and shall successfully complete a class before doing a delegated task.

11.4.8. **Personal Care Services**: Personal Care tasks include:

- 11.4.8.1. Ambulation;
- 11.4.8.2. Bathing;
- 11.4.8.3. Body Care;
- 11.4.8.4. Dressing;
- 11.4.8.5. Eating;
- 11.4.8.6. Essential shopping;
- 11.4.8.7. Housework;
- 11.4.8.8. Laundry;
- 11.4.8.9. Meal preparation;
- 11.4.8.10. Personal Hygiene;
- 11.4.8.11. Self-medication administration;
- 11.4.8.12. Supervision;
- 11.4.8.13. Toileting;

11.4.8.14. Transfer;
11.4.8.15. Travel to medical services (appointments?); and
11.4.8.16. Wood supply.

Personal care can be both physical assistance and/or prompting and supervising the performance of direct personal care tasks and household tasks. Such services may be provided for clients who are functionally unable to perform all or part of such tasks or who are incapable of performing the tasks without specific instructions. Personal care services do not include assistance with tasks that are performed by a licensed health professional. Individual or agency providers perform these duties.

11.4.9. **Personal Emergency Response System (PERS):** An electronic devise is provided that allows clients to get help in an emergency. The system is connected to a phone or the enrollee may also wear a portable "help" button. When activated, staff at a response center will call 911 and/or take whatever action has been set-up ahead of time.

11.4.10. **Self-Directed Care:** An adult with a functional disability, living in his/her own home can direct and supervise a paid personal care aide to help them with health care tasks that he/she can't do because of his or her disability. Examples of self-directed care tasks include medications, bowel programs, bladder catheterization, and wound care. Self directed care supports an individual's autonomy and choice and often allows him/her to stay in his/her own home longer.

11.4.11. **Home Delivered Meals:** Nutritious meals and other dietary services are provided in a group setting or delivered to home-bound persons.

11.4.12. **Adult Family Homes:** Adult family homes are residential, neighborhood homes licensed by Washington State to care for two to six people. Adult family homes provide lodging, meals, laundry, and organized social activities or outings. If it is needed, they also provide necessary supervision, assist with personal care (getting dressed, bathing, etc.) and help with medications. Some provide nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

11.4.13. **Boarding Homes:** Boarding homes are larger facilities licensed by Washington State to care for seven or more people. Boarding homes provide lodging, meal services, assistance with personal care, and general supervision of residents. Some provide limited nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

11.4.13.1. Boarding homes that provide care for state-funded clients are contracted under the following categories.

11.4.14. **Adult Residential Care:** Adult Residential Care (ARC) services include lodging, meal services, general supervision of residents, and assistance with personal care.

11.4.15. **Enhanced Adult Residential Care:** Includes everything provided through and ARC contract (See above) plus limited nursing services.

11.4.16. **Assisted Living (AL):** Includes everything provided through an EARC contract (see above) plus offering residents private apartment-like units with a private bath and kitchen area.

11.4.17. **Nursing facilities (Homes):** Nursing facilities provide 24-hour a day supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. Nursing facilities also offer short-term rehabilitation services.

11.5. **Individual Providers**: The Contractor shall ensure that all potential Individual Providers (IPs) meet the minimum qualifications for care providers in home settings as described in WAC 388-71 are therefore qualified to perform the following services:

11.5.1. Assist, as specified by the client, with those personal care services, authorized household tasks, and/or nurse delegated or self-directed health care tasks, which are included in the enrollee's service plan.

11.5.2. Perform all services in a manner consistent with protecting and promoting the client's health, safety and well-being.

11.5.3. No Individual Provider will perform any task requiring a registration, certificate or license unless he or she is registered, certified or licensed to do so, is a member of the enrollee's immediate family, or is performing self-directed health care tasks. RCW 18.79, 19.88 and 74.39 provide more information about regulations related to nursing care, Registered Nurse Delegation and self-directed health care tasks.

11.6. **Medical Services:** The Contractor shall provide medical services as follows:

11.6.1. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the state of Washington. The Contractor is not responsible for the coverage of the services provided through such separate arrangements. The enrollees also may choose to receive such services from the Contractor.

The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for such services up to the limits described herein.

11.6.2. The services to which an enrollee may self-refer are:

11.6.2.1. Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

11.6.2.2. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

11.6.3. **Inpatient Services**: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

11.6.4. **Outpatient Hospital Services**: Provided by acute care hospitals (licensed under RCW 70.41).

11.6.5. **Emergency Services and Post-stabilization Services**:

11.6.5.1. **Emergency Services:** Emergency services are defined herein.

11.6.5.1.1. The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

11.6.5.1.2. The Contractor shall cover all emergency services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.6.5.1.3. Emergency services shall be provided without requiring prior authorization.

11.6.5.1.4. What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(i)).

11.6.5.1.5. The Contractor shall cover treatment obtained under the following circumstances:

11.6.5.1.5.1. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

11.6.5.1.5.2. A plan provider or other Contractor representative instructs the enrollee to seek emergency services.

11.6.5.1.6. If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

11.6.5.2. **Post-stabilization Services**: Post-stabilization services are defined herein.

11.6.5.2.1. The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

11.6.5.2.2. The Contractor shall cover all post-stabilization services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.6.5.2.3. The Contractor shall cover post-stabilization services under the following circumstances:

11.6.5.2.3.1. The services are pre-approved by a plan provider or other Contractor representative.

11.6.5.2.3.2. The services are not pre-approved by a plan provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

11.6.5.2.3.3. The services are not pre-approved by a plan provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and:

11.6.5.2.3.3.1. The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

11.6.5.2.3.3.2. The Contractor cannot be contacted; or

11.6.5.2.3.3.3. The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria in Section 11.1.6.4.2.3.4. is met.

11.6.5.2.3.4. The Contractor's responsibility for post-stabilization services it has not pre-approved ends when:

11.6.5.2.3.4.1. A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

11.6.5.2.3.4.2. A participating provider assumes responsibility for the enrollee's care through transfer;

11.6.5.2.3.4.3. A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

11.6.5.2.3.4.4. The enrollee is discharged.

11.6.6. **Ambulatory Surgery Center**: Services provided at ambulatory surgery centers.

11.6.7. **Provider Services**: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician

assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider Services include, but are not limited to:

11.6.7.1. Medical examinations, including wellness exams

11.6.7.2. Immunizations

11.6.7.3. Family planning services provided or referred by a participating provider or practitioner

11.6.7.4. Performing and/or reading diagnostic tests

11.6.7.5. Private duty nursing

11.6.7.6. Surgical services

11.6.7.7. Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

11.6.7.8. Anesthesia

11.6.7.9. Administering pharmaceutical products

11.6.7.10. Fitting prosthetic and orthotic devices

11.6.7.11. Rehabilitation services

11.6.7.12. Enrollee health education

11.6.7.13. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia

11.6.8. **Tissue and Organ Transplants:** Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

11.6.9. **Laboratory, Radiology, and Other Medical Imaging Services:** Screening and diagnostic services and radiation therapy.

11.6.10. **Vision Care:** Eye examinations for visual acuity and refraction once every twenty-four (24) months. These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

11.6.11. **Occupational Therapy, Speech Therapy, and Physical Therapy:** Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.

11.6.12. **Pharmaceutical Products:** Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products shall include:

11.6.12.1. Oral, enteral and parenteral nutritional supplements and supplies.

11.6.12.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies;

11.6.12.3. Antigens and allergens;

11.6.12.4. Therapeutic vitamins and supplements;

11.6.12.5. The Contractor must ensure that procedures for pharmaceutical management promote clinically appropriate use of pharmaceuticals.

11.6.12.5.1. Procedures must include criteria used for adoption of pharmaceutical management procedures.

11.6.12.5.2. Procedures must include the process for using external organization's clinical evidence for pharmaceutical management.

11.6.13. **Durable Medical Equipment (DME) and Supplies:** Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; incontinence supplies; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

11.6.14. **Oxygen and Respiratory Services:** Oxygen, and respiratory therapy equipment and supplies.

11.6.15. **Hospice Services:** When the enrollee elects hospice care.

11.6.16. **Blood, Blood Components and Human Blood Products:** Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the Contractor shall cover the cost of the blood or blood products.

11.6.17. **Treatment for Renal Failure:** Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

11.6.18. **Ambulance Transportation:** The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

11.6.18.1. When it is necessary to transport an enrollee between facilities to receive a covered services; and

11.6.18.2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

11.6.19. **Smoking Cessation Services:** As determined Medically Necessary by the Care Coordinator.

11.7. **Exclusions:**

The following services and supplies are excluded from coverage under this agreement. This shall not be construed to prevent the Contractor from covering any of these services when the Contractor determines it is medically necessary. Unless otherwise required by this agreement, ancillary services resulting from excluded services are also excluded.

11.7.1. **Services Covered By DSHS Fee-For-Service Or Through Selective Contracts with other providers:**

11.7.1.1. Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

11.7.1.2. Transportation Services other than Ambulance: Taxi, cabulance, voluntary transportation, and public transportation.

11.7.1.3. Dental Care, Prostheses and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery.

11.7.1.4. Hearing Aid Devices, including fitting, follow-up care and repair.

11.7.1.5. Sterilizations that do not meet other federal requirements.

11.7.1.6. Health care services provided by a neurodevelopmental center recognized by DSHS.

11.7.1.7. Certain services provided by a health department or family planning clinic when a client self-refers for care.

11.7.1.8. Inpatient psychiatric professional services.

11.7.1.9. Pharmaceutical products prescribed by any provider related to services provided under a separate agreement with DSHS or related to services not covered by the Contractor.

11.7.1.10. Protease Inhibitors

11.7.1.11. Services provide for ventilator – trach. & traumatic brain injury clients under bundled rates.

11.7.1.12. Gastroplasty, when approved by DSHS in accord with WAC 388-531. The Contractor has no obligation to cover gastroplasty.

11.7.1.13. Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

11.7.2. **Services Covered By Other Divisions In The Department Of Social And Health Services**:

11.7.2.1. Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

11.7.2.2. Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA), inpatient detoxification services.

11.7.2.3. Mental Health services separately purchase for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, and inpatient psychiatric services. This shall not be construed to prevent the

Contractor from purchasing covered outpatient mental health services from community mental health providers.

11.7.3. **Services Not Covered by Either DSHS or the Contractor:**

11.7.3.1. Medical examinations for Social Security Disability.

11.7.3.2. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

11.7.3.3. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

11.7.3.4. Experimental and Investigational Treatment or Services, determined in accord with Section 10.16, Experimental and Investigational Services, and services associated with experimental or investigational treatment or services.

11.7.3.5. Reversal of voluntary surgically induced sterilization.

11.7.3.6. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

11.7.3.7. Biofeedback Therapy.

11.7.3.8. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

11.7.3.9. Orthoptic (eye training) care for eye conditions.

11.7.3.10. Tissue or organ transplants that are not specifically listed as covered.

11.7.3.11. Immunizations required for international travel purposes only.

11.7.3.12. Any service, product, or supply paid for by DSHS under its fee-for-service program only on an exception to policy basis. The Contractor may also make exceptions and pay for services it is not required to cover under this agreement.

11.7.3.13. Any other service, product, or supply not covered by DSHS under its fee-for-service program.

11.7.3.14. Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody.

Exhibit A
Quality Improvement Program Standards

The Contractor shall comply with the Quality Improvement Program Standards. In the event of conflict between the Quality Improvement Program Standards and the standards in Balance Budget Act Final Rules (BBA), Washington State Patient Bill of Rights (PBOR), Health Insurance Portability and Accountability Act (HIPAA), or any other applicable state or federal statutes or regulations, the standards in BBA, PBOR, HIPAA, or any other applicable state or federal statutes or regulations, and any provision elsewhere in this Contract that implements such statutes or regulations, shall have precedence. Also see Section 7.10 Order of Precedence.

The following NCQA definitions apply to terms used in this document:

Complaint: A complaint is the same as "grievance." See 1. Definitions.

Denial a denial is the same as "action." See 1. Definitions.

NCQA STANDARDS

QUALITY MANAGEMENT AND IMPROVEMENT

QI 1	PROGRAM STRUCTURE
	The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.
ELEMENT A: Quality Improvement Program Structure	
	The organization's QI program structure includes the following factors:
1	a written description of the QI program
3	patient safety is specifically addressed in the program description
4	the QI program accountable to the governing body
5	an annual evaluation of the program description and updates, as necessary
6	a designated physician has substantial involvement in the QI program
7	a designated behavioral health practitioner is involved in the implementation of the behavioral health care aspects of the QI program.
8	a QI committee oversees the QI functions of the organization
9	The specific role, structure, and function of the QI committee and other committees, including meeting frequency, are addressed in the program description
10	an annual work plan
11	A description of resources that the organization devotes to the needs of the QI program.
ELEMENT C: Annual Evaluation of Quality Improvement Program	
	There is an annual written evaluation of the QI program that includes:
1	a description of completed and ongoing QI activities that address the quality and safety of clinical care and quality of service
2	trending of measures to assess performance in the quality and safety of clinical care and quality of service
3	analysis of the results of QI initiatives, including barrier analysis
4	evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.
QI 2	PROGRAM OPERATIONS
	The organization's quality improvement program is fully operational.
ELEMENT A: The QI Committee	
	The organization's QI committee:
1	recommends policy decisions

NCQA STANDARDS	
2	analyzes and evaluates the results of QI activities
3	institutes needed actions
4	ensures follow-up, as appropriate.
ELEMENT B: QI Committee Meeting Minutes	
	QI committee meeting minutes reflect all committee decisions
ELEMENT C: Practitioner Participation	
	Practitioners participate in the QI program through planning, design, implementation or review
ELEMENT D: QI Program Information for Practitioners and Members	
	Upon request, the organization makes information about its QI program available to its practitioners and members, including a description of the QI program and a report on the organization's progress in meeting its goals.
QI 3	HEALTH SERVICES CONTRACTING
	The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with the organization's QI program.
ELEMENT A: Practitioner Contracts	
	Contracts with practitioners specifically require that:
1	practitioners cooperate with QI activities
2	the organization has access to practitioner medical records, to the extent permitted by state and federal law
3	practitioners maintain the confidentiality of member information and records
ELEMENT B: Practitioner – Patient Communication	
	Contracts with practitioners allow open practitioner-patient communication regarding appropriate treatment alternatives. The organization does not penalize practitioners for discussing medically necessary or appropriate patient care.
ELEMENT C: Affirmative Statement	
	Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.
ELEMENT D: Provider Contracts	
	Contracts with organization providers specifically require that:
1	providers cooperate with QI activities
2	the organization has access to provider medical records, to the extent permitted by state and federal law.
3	providers maintain the confidentiality of member information and records
ELEMENT E: Notification of Specialist Termination	
	Contracts with specialists and specialty group practitioners require timely notification to organization members affected by the termination of a specialist or the entire specialty group.

NCQA STANDARDS	
QI 4	AVAILABILITY OF PRACTITIONERS
	The organization ensures that its network is sufficient in numbers and types of primary care and specialty care practitioners.
ELEMENT A: Cultural Needs and Preferences	
	The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.
ELEMENT B: Defining Primary Care Practitioners	
	The organization defines the practitioners who serve as primary care practitioners (PCP) within its delivery system.
ELEMENT C: Number and Geographic Distribution of Primary Care Practitioners	
	The organization has quantifiable and measurable standards for:
1	the number of PCPs
2	the geographic distribution of PCPs.
ELEMENT D: Annual Performance Assessment of Primary Care Practitioners	
	The organization annually assesses its performance against the standards established for the availability of PCPs.
ELEMENT E: Defining Specialty Care Practitioners	
	The organization defines which practitioners serve as high-volume specialty care practitioners (SCP).
ELEMENT F: Number and Geographic Distribution of Specialists	
	The organization has quantifiable and measurable standards for:
1	the number of high-volume SCPs
2	the geographic distribution of high-volume SCPs.
ELEMENT G: Annual Performance Assessment of Specialists	
	The organization annually analyzes its performance against the standards established for the availability of high-volume SCPs.
QI 5	ACCESSIBILITY OF SERVICES
	The organization establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member/enrollee services.
ELEMENT A: Standards for Medical Care Access	
	The organization has standards for access to:
1	regular and routine care appointments
2	urgent care appointments;
3	after-hours care.
4	telephone service.
ELEMENT B: Assessment Against Medical Access Standards	

NCQA STANDARDS	
	The organization collects and performs an annual analysis of data to measure its performance against standards for access to:
1	regular and routine care appointments
2	urgent care appointments;
3	after-hours care.
4	telephone service.
QI 6	MEMBER SATISFACTION
	The organization implements mechanisms to assure member satisfaction.
ELEMENT A: Annual Assessment	
	To assess member satisfaction, the organization conducts annual evaluations of member complaints and appeals.
ELEMENT B: Data Collection Methodology	
	The organization's complaint and appeal data collection methodology:
1	identifies the appropriate population
2	draws appropriate samples from the affected population, if a sample is used
3	collects valid data.
ELEMENT C: Identifying Opportunities for Improvement	
	The organization identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based upon the analysis of:
1	member complaint and appeal data
2	The CAHPS® 3.0H Survey.
ELEMENT D: Reporting to Practitioners	
	The organization shares the results of its improvement and member satisfaction activities with practitioners and providers.
QI 7	DISEASE MANAGEMENT
	The organization actively works to improve the health status of its members with chronic conditions.
ELEMENT A: Identifying Chronic Conditions	
	The organization identifies the two chronic conditions that its disease management (DM) programs address.
1. ELEMENT B: Program Content	
	The content of the organization's programs address the following for each condition:
1	condition monitoring
2	patient adherence to the program's treatment plans
3	consideration of other health conditions
4	lifestyle issues as indicated by practice guidelines (e.g. goal-setting techniques, problem solving).

NCQA STANDARDS	
ELEMENT C: Identifying Eligible Members	
	Annually, the organization systematically identifies members who qualify for its programs.
i. ELEMENT D: Providing Eligible Members With Information	
	The organization provides eligible members with written program information regarding:
1	how to use the services
2	how members become eligible to participate
3	how to opt in or opt out.
2. ELEMENT E: Interventions Based on Stratification	
	The organization provides interventions to members based on stratification.
3. ELEMENT F: Eligible Member Participation	
	The organization annually measures and reports member participation rates
ELEMENT G: Informing and Educating Practitioners About Disease Management Programs	
	The organization has a documented process for providing practitioners with written program information, including:
1	instructions on how to use the DM services
2	how the organization works with a practitioner's members in the program.
4. ELEMENT H: Measuring Effectiveness	
	The organization employs and tracks one performance measure for each DM program. Each measurement:
1	addresses a relevant process or outcome
2	produces a quantitative result
3	is population based
4	uses data and methodology that are valid for the process or outcome measured
5	has been analyzed in comparison to a benchmark or goal.
QI 8	CLINICAL PRACTICE GUIDELINES
	Guidelines removed, not applicable to WMIP.
QI 9	CONTINUITY AND COORDINATION OF MEDICAL CARE
	The organization monitors the continuity and coordination of care that members receive and takes actions, as necessary, to ensure and improve continuity and coordination of care across the health care network.
ELEMENT A: Continuity and Coordination of Medical Care	
	The organization annually collects data about the coordination of medical care across settings or transitions in care.
ELEMENT B: Identifying Opportunities for Improvement of Medical Care Coordination	
	The organization identifies opportunities to improve coordination of medical care. There is documentation of the following factors:

NCQA STANDARDS	
1	quantitative and causal analysis of data to identify improvement opportunities
2	identification and selection of at least two opportunities for improvement.
ELEMENT C: Medical Coordination Issues	
	The organization takes action to improve coordination of medical care.
ELEMENT D: Notification of Primary Care Practitioner Termination	
	Requirement removed, not applicable to WMIP.
QI 11	CLINICAL QUALITY IMPROVEMENTS
	Requirement removed, not applicable to WMIP.
QI 12	SERVICE QUALITY IMPROVEMENTS
	Requirement removed, not applicable to WMIP.
QI 13	STANDARDS FOR MEDICAL RECORD DOCUMENTATION
	The organization requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.
ELEMENT A: Medical Record Criteria	
	The organization has policies and distributes the policies to practice sites that address:
1	confidentiality of medical records
2	medical record documentation standards
3	an organized medical record keeping system and standards for availability of medical records
4	performance goals to assess the quality of medical record keeping.
ELEMENT B: Documentation Standards	
	The organization's medical record standards or their predecessors have been in place for at least 12 months
ELEMENT C: Improving Medical Record Keeping	
	The organization implements a method(s) to improve medical record keeping
QI 14	DELEGATION OF QI
	If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.
ELEMENT A: Written Delegation Agreement	
	There is a mutually agreed-upon document that describes all delegated activities
ELEMENT B: Specific Delegated Activities	
	The delegation document describes:
1	the responsibilities of the organization and the delegated entity
2	the delegated activities
3	at least semiannual reporting to the organization

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4	the process by which the organization evaluates the delegated entity's performance
5	the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
ELEMENT C: Provisions for Protected Health Information	
	If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:
1	a list of the allowed uses of protected health information
2	a description of delegate safeguards to protect the information from inappropriate use of further disclosure
3	a stipulation that the delegate ensures that sub delegates have similar safeguards
4	a stipulation that the delegate provide individuals with access to their protected health information
5	a stipulation that the delegate informs the organization if inappropriate uses of the information occur
6	a stipulation that the delegate ensures protected health information is returned, destroyed or protected if the delegation agreement ends.
ELEMENT D: Approval of QI Program	
	Annually, the organization approves its delegates QI program.
ELEMENT E: Pre-Delegation Evaluation	
	For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.
ELEMENT F: Annual Evaluation	
	For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.
ELEMENT G: Reporting	
	For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element B.
ELEMENT H: Opportunities for Improvement	
	For delegation arrangements that have been in effect for more than 12 months, at least once each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.
UTILIZATION MANAGEMENT	
UM 1	Utilization Management Structure
	The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility appropriate individuals.
ELEMENT A: Written Program Description	
	The organization's UM program description includes the following factors:

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1	program structure
2	behavioral health care aspects of the program
3	involvement of a designated senior physician in UM program implementation
4	involvement of a designated behavioral health care practitioner in the implementation of the behavioral health care aspects of the UM program
5	scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.
ELEMENT C: Physician Involvement	
	A senior physician is actively involved in implementing the organization's UM program.
ELEMENT D: Behavioral Health Practitioner Involvement	
	A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM program.
ELEMENT E: Annual Evaluation	
	The organization annually evaluates and updates the UM program, as necessary.
UM 2	Clinical Criteria for UM Decisions
	To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.
ELEMENT A: Evidence-Based, Written Criteria	
	The organization has written UM decision-making criteria that are objective and based on medical evidence.
ELEMENT B: Applying Utilization Management Criteria	
	The organization has written procedures for applying UM criteria based on:
1	individual needs
2	assessment of the local delivery system.
ELEMENT C: Involvement of Appropriate Practitioners	
	The organization involves appropriate practitioners in developing, adopting and reviewing criteria applicability
ELEMENT D: Length of Time Criteria Are in Place	
	The organization's UM criteria have been in place for at least 12 months
ELEMENT E: Reviewing and Updating Criteria	
	The organization has a process for periodically reviewing and updating UM criteria and the procedures for applying them.
ELEMENT F: Availability of Criteria	
	The organization states in writing how practitioners can obtain UM criteria, and makes the criteria available to its practitioners upon request.
ELEMENT G: Consistency in Applying Criteria	

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	The organization annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision making and acts on opportunities for improvement, if applicable.
UM 4	Appropriate Professionals
	Qualified licensed health professionals assess the clinical information used to support UM decisions.
ELEMENT A: Licensed Health Professionals	
	The organization has written procedures:
1	requiring appropriately licensed professionals to supervise all medical necessity decisions
ELEMENT B: Use of Practitioners for UM Decisions	
	The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity that requires:
1	education, training or professional experience in medical or clinical practice
2	current license to practice without restriction.
ELEMENT C: Non-Behavioral Health Practitioner Review of Denials	
	The organization ensures that a physician, dentist or pharmacist, as appropriate, reviews any non-behavioral health denial of care based on medical necessity.
ELEMENT D: Behavioral Health Practitioner Review of Denials	
	The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.
ELEMENT E: Use of Board-Certified Consultants	
	The organization has written procedures for using board-certified consultants to assist in making medical necessity determinations.
UM 5	Timeliness of UM Decisions
	The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.
ELEMENT A: Timeliness of Decision Making for Non-Behavioral Health UM Decisions	
	The organization adheres to the following standards for timeliness of UM decision making:
1	for non-urgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request [HCA & MAA require non-urgent, pre-service decisions within 14 calendar days]
2	for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request
3	for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request
4	for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.
ELEMENT B: Notification of Non-Behavioral Health Decisions	
	The organization adheres to the following standards for notification of non-behavioral health UM decision making:
1	for non-urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to

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	practitioners and members within 15 calendar days of the request [HCA & MAA require non-urgent, pre-service decisions within 14 calendar days]
2	for non-urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request
3	for urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 72 hours of the request
4	for urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request
5	for urgent concurrent approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request
6	for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request
7	for post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.
ELEMENT C: Timeliness of Decision Making for Behavioral Health UM Decisions	
	The organization adheres to the following standards for timeliness of behavioral health UM decision making:
1	for non-urgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request [HCA & MAA require non-urgent, pre-service decisions within 14 calendar days]
2	for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request
3	for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request
4	for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.
ELEMENT D: Notification of Behavioral Health Decisions	
	The organization adheres to the following standards for notification of behavioral health UM decision making:
1	for non-urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 15 calendar days of the request
2	for non-urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request
3	for urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 72 hours of the request
4	for urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request
5	for urgent concurrent approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request

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6	for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request
7	for post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.
UM 6	Clinical Information
	When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.
ELEMENT A: Information for UM Decision Making	
	The organization has a written description that identifies the information that is needed to support UM decision making in place for at least 12 months.
ELEMENT C: Non-Behavioral Health Documentation of Relevant Information	
	There is documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision making.
ELEMENT D: Behavioral Health Documentation of Relevant Information	
	There is documentation that relevant clinical information is gathered consistently to support behavioral health UM decision making.
ELEMENT E: Transition to Other Care	
	The organization assists with a member's transition to other care, if necessary, when benefits end.
UM 7	Denial Notices
	The organization clearly documents and communicates the reasons for each denial.
ELEMENT A: Notification of the Availability of Physician, Appropriate Behavioral Health or Pharmacist Reviewers	
	The organization notifies practitioners of:
1	its policy for making a reviewer available to discuss any UM denial decision
2	how to contact a reviewer.
ELEMENT B: Providing Practitioners the Opportunity to Discuss Non-Behavioral Health Denial Decisions with a Physician or Pharmacist Reviewer	
	The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or pharmacist reviewer.
ELEMENT C: Reason for Non-Behavioral Health Denial	
	The organization provides written notification that contains the following:
1	the specific reason(s) for the denial, in easily understandable language
2	a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
3	notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on

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	which the denial decision was based, upon request.
ELEMENT D: Non-Behavioral Health Notification of Appeal Rights and Process	
	The organization provides written notification that contains the following:
1	description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
2	explanation of the appeal process, including the right to member representation and time frames for deciding appeals
3	if a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process.
ELEMENT E: Providing Practitioners the Opportunity to Discuss Behavioral Health Denial Decisions with a Physician, Appropriate Behavioral Health or Pharmacist Reviewer.	
	The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.
ELEMENT F: Reason for Behavioral Health Denial	
	The organization provides written notification that contains the following:
1	the specific reason(s) for the denial, in easily understandable language
2	a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based
3	notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
ELEMENT G: Behavioral Health Notification of Appeal Rights and Appeal process	
	The organization provides written notification that contains the following:
1	description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
2	explanation of the appeal process, including the right to member representation and time frames for deciding appeals
3	if a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process.
UM 8	Policies for Appeals
	The organization has written policies and procedures for the thorough, appropriate, and timely resolution of member appeals. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).
UM 9	Appropriate Handling of Appeals
	The organization adjudicates member appeals in a thorough, appropriate and timely manner. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).
UM 10	Evaluation of New Technology
	The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral procedures, pharmaceuticals and devices.
ELEMENT A: Written Process	

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	The organization's written process for evaluating new technologies and the new application of existing technologies for inclusion in its benefit package includes an evaluation of the following factors:
1	medical technologies
2	behavioral health procedures
3	pharmaceuticals
4	devices.
ELEMENT C: Implementation of Evaluated New Technology	
	The organization implements a decision on coverage from its assessment of new technologies and new applications of existing technologies or from review of special cases.
UM 12	Emergency Services
	The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.
ELEMENT A: Emergency Services Policies and Procedures	
	The organization's policies and procedures require:
1	coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed
2	coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency services.
UM 13	Procedures for Pharmaceutical Management
	The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.
	ELEMENT A: Pharmaceutical Management Policies and Procedures
	The organization's policies and procedures for pharmaceutical management include:
1	the criteria used to adopt pharmaceutical management procedures
2	a process that uses clinical evidence from appropriate external organizations.
UM 14	Ensuring Appropriate Utilization
	The organization facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under- and over utilization of services.
ELEMENT A: Relevant Utilization Data	
	The organization chooses at least four relevant types of utilization data, including one type related to behavioral health to monitor for each product line.
ELEMENT B: Under/Over utilization Thresholds	
	The organization sets thresholds to identify under- and over utilization for the four chosen data types, including behavioral

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	health data, by product line.
ELEMENT C: Monitoring Data	
	Annually, the organization monitors the performance of the four chosen data types, including behavioral health data, against established thresholds for each product line to detect under- and over utilization.
ELEMENT D: Quantitative Data Analysis	
	Annually, the organization analyzes the performance of the four chosen data types, including behavioral health data, against established thresholds for each product line to detect under- and over utilization.
ELEMENT E: Qualitative Data Analysis	
	The organization conducts qualitative analysis to determine the cause and effect of all data not within thresholds.
ELEMENT F: Site-Level Monitoring	
	The organization analyzes data not within threshold by practice sites.
ELEMENT G: Interventions	
	The organization takes action to address identifies problems of under- and over utilization.
ELEMENT H: Evaluating the Effectiveness of Interventions	
	The organization measures the effectiveness of interventions to address under- and over utilization.
ELEMENT I: Affirmative Statement Regarding Incentives	
	The organization distributes a statement to all its practitioners, providers, members and employees affirming that:
1	UM decision making is based only on appropriateness of care and service and existence of coverage
2	the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care
3	financial incentives for UM decision makers do not encourage decisions that result in underutilization.
UM 16	Delegation of UM
	If the managed care organization delegates any UM activities, there is evidence of oversight of the delegated activity.
ELEMENT A: Written Delegation Agreement	
	There is a mutually agreed-upon document that describes all delegated activities.
ELEMENT B: Specific Delegated Activities	
	The delegation document describes:
1	the responsibilities of the organization and the delegated entity
2	the delegated activities
3	at least semi-annual reporting to the organization
4	the process by which the organization evaluates the delegated entity's performance
5	the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

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ELEMENT C: Provision for Protected Health Information	
	If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:
1	a list of the allowed uses of protected health information
2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3	a stipulation that the delegate will ensure that sub delegates have similar safeguards
4	a stipulation that the delegate will provide individuals with access to their protected health information
5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur
6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.
ELEMENT D: Approval of UM Program	
	Annually, the organization approves its delegate's UM program.
ELEMENT E: Pre-Delegation Evaluation	
	For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.
ELEMENT F: Annual Evaluation	
	For delegation arrangements in effect 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.
ELEMENT G: Reporting	
	For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element B.
ELEMENT H: Opportunities for Improvement	
	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.
CREDENTIALING AND RECREDENTIALING	
CR 1	Credentialing Policies
	The organization documents the mechanisms for the credentialing and re-credentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action.
ELEMENT A: Practitioner Credentialing Guidelines	
	The organization's credentialing policies and procedures specify the types of practitioners to credential and re-credential.
ELEMENT B: Criteria and Verification Sources	
	The organization's policies and procedures specify:

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1	the criteria for credentialing and re-credentialing
2	the verification sources used.
ELEMENT C: Policies and Procedures	
	The organization's policies and procedures include the following factors:
1	the process to delegate credentialing or re-credentialing;
2	the process used to ensure that credentialing and re-credentialing are conducted in a non-discriminatory manner
3	the process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner
4	the process to ensure that practitioners are notified of the credentialing or re-credentialing decision within 60 calendar days of the committee's decision
5	the medical director's or other designated physician's direct responsibility and participation in the credentialing program
6	the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law
7	the process for making credentialing and re-credentialing decisions.
ELEMENT D: Practitioners Rights	
	The organization's policies and procedures include the following practitioner rights:
1	the right of practitioners to review information submitted to support their credentialing applications
2	the right of practitioner's to correct erroneous information;
3	the right of practitioners, upon request, to be informed of the status of their credentialing or re-credentialing application
4	notification of these rights.
CR 2	Credentialing Committee
	The organization designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.
ELEMENT A: Credentialing Committee	
	The Credentialing Committee includes representation from a range of participating practitioners.
ELEMENT B: Credentialing Committee Decisions	
	The Credentialing Committee has the opportunity to review the credentials of all practitioners and offer advice, which the organization considers.
CR 3	Initial Credentialing Verification
	The organization verifies credentialing information through primary sources, unless otherwise indicated.
ELEMENT A: Initial Primary Source Verification	
	The organization verifies that the following factors are present and within the prescribed time limits:

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1	a current, valid license to practice
2	a valid DEA or CDS certificate, if applicable
3	education and training including board certification if the practitioner states on the application that he/she is board certified
4	work history
5	history of professional liability claims that resulted in settlements or judgments paid by on behalf of the practitioner.
CR 4	Application and Attestation
	The applicant completes an application for membership that includes a current and signed attestation regarding the applicant's health status and any history of loss or limitation of licensure or privileges:.
ELEMENT A: Contents of the Application	
	The application includes a current and signed attestation and addresses:
1	reasons for any inability to perform the essential functions of the position, with or without accommodation
2	lack of present illegal drug use
3	history of loss of license and felony convictions
4	history of loss or limitation of privileges or disciplinary activity
5	current malpractice insurance coverage
6	the correctness and completeness of the application.
CR 5	Initial Sanction Information
	There is documentation that before making a credentialing decision the organization has received information on sanctions.
ELEMENT A: Sanctions	
	In an NCQA review of credentialing files, two factors are present and within 180 calendar day time limit:
1	state sanctions, restrictions on licensure and/ or limitations on scope of practice
2	Medicare and Medicaid sanctions.
CR 7	Re-credentialing Verification
	The organization formally re-credentials its practitioners at least every 36 months through information verified from primary sources, unless otherwise indicated.
ELEMENT A: Re-credentialing Verification	
	The organization verifies the following factors within the prescribed time limits:
1	a current valid state license to practice
2	a valid DEA or CDS certificate, as applicable
3	board certification, if the practitioner states that he/she is board certified
4	history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.
ELEMENT B: Correctness/Completeness of the Application	

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	An applicant completes an application for membership that includes a current and signed attestation with the following factors:
1	reasons for any inability to perform the essential functions of the position, with or without accommodation
2	lack of present illegal drug use
3	history of loss or limitation of privileges or disciplinary activity
4	current malpractice insurance coverage
5	correctness and completeness of the application.
ELEMENT C: Re-credentialing Cycle Length	
	The length of the re-credentialing cycle is within the required 36 month time frame.
CR 8	Re-credentialing Sanction Information
	There is documentation that before making a re-credentialing decision, the organization has received information on sanctions.
ELEMENT A: Sanction Information	
	In an NCQA review of re-credentialing files, two elements are present and within 180 calendar day time limit:
1	state sanctions, restrictions on licensure and/or limitations on scope of practice
2	Medicare and Medicaid sanctions.
ELEMENT B: Re-credentialing Cycle Length	
	In a review of a sample of the organization's re-credentialing files, the length of the re-credentialing cycle is within the 3 year (36 month) time frame.
CR 9	Performance Monitoring
	The organization incorporates information from quality improvement activities and member complaints in its re-credentialing decision-making process for primary care practitioners and high-volume behavioral health care practitioners.
ELEMENT A: Decision-Making Process	
	The organization includes information from quality improvement activities and member complaints in its re-credentialing decision-making process for PCPs and high-volume behavioral health care practitioners.
CR 10	Ongoing Monitoring of Sanctions and Complaints
	The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions and complaints between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.
ELEMENT A: Written Policy and Procedures	
	The organization has a written policy and procedure that addresses the ongoing monitoring of:
1	Medicare and Medicaid sanctions
2	sanctions and limitations on licensure

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3	complaints.
ELEMENT C: Implementing ongoing Monitoring	
	The organization collects and reviews information from:
1	Medicare and Medicaid sanctions
2	sanctions and limitations on licensure
3	complaints.
ELEMENT D: Appropriate Interventions	
	The organization implements appropriate interventions when it identifies occurrences of poor quality, when appropriate.
CR 11	Notification to Authorities and Practitioner Appeal Right
	When an organization has taken actions against a practitioner for quality reasons, it offers the practitioner a formal appeal process and reports the action to the appropriate authorities.
ELEMENT A: Written Policy and Procedures	
	The organization has policies and procedures for:
1	the range of actions available to the organization
2	procedures for reporting to authorities
3	a well-defined appeal process
4	making the appeal process known to practitioners.
ELEMENT B: Contract Suspension or Termination	
	There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.
ELEMENT C: Practitioner Approval Process	
	The organization has an appeal process for instances in which it chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service. The organization informs practitioners of the appeal process.
CR 12	Assessment of Organizational Providers
	The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.
ELEMENT A: Review and Approval of Provider	
	The organization's policy for credentialing of health care delivery providers specifies that it:
1	confirms that the provider is in good standing with state and federal regulatory bodies
2	confirms that the provider has been reviewed and approved by an accrediting body
3	conducts an on-site quality assessment, if there is no accreditation status
4	confirms that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body at least every 3 years.

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ELEMENT B: Medical Providers	
	The organization includes at least the following medical providers:
1	hospitals
2	home health agencies
3	skilled nursing facilities
4	free-standing surgical centers.
ELEMENT D: Assessing Medical Care Providers	
	The organization has documentation of assessment of contracted medical health care delivery providers.
CR 13	Delegation of Credentialing
	If the organization delegates any credentialing and re-credentialing activities, there is evidence of oversight of the delegated activity.
ELEMENT A: Written Delegation Agreement	
	There is a mutually agreed-upon document that describes all delegated activities.
ELEMENT B: Specific Delegated Activities	
	The delegation document describes:
1	the responsibilities of the organization and the delegated entity
2	the delegated activities
3	at least semi-annual reporting to the organization
4	the process by which the organization evaluates delegated entity's performance
5	the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
ELEMENT C: Provisions for Protected Health Information	
	If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:
1	a list of the allowed uses of protected health information
2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3	a stipulation that the delegate will ensure that sub delegates have similar safeguards
4	a stipulation that the delegate will provide individuals with access to their protected health information
5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur
6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.
ELEMENT D: Right to Approve and to Terminate	

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	The organization retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making. This right is reflected in the delegation documents.
ELEMENT E: Pre-Delegation Evaluation	
	For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.
ELEMENT F: Annual File Audit	
	For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards for each year that the delegation has been in effect.
ELEMENT G: Annual Evaluation	
	For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.
ELEMENT H: Reporting	
	For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element B.
ELEMENT I: Opportunities for Improvement	
	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.
MEMBERS' RIGHTS AND RESPONSIBILITIES	
RR 1	Statement of Members' Rights and Responsibilities
	The organization has a written policy that states its commitment to treating members in a manner that respects their rights and its expectations of members' responsibilities.
ELEMENT B: Statement of Members' Rights and Responsibilities	
	The organization's members' rights and responsibilities policy states that members have:
1	a right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities
2	a right to be treated with respect and recognition of their dignity and right to privacy
3	a right to participate with practitioners in decision-making regarding their health care
4	a right to a candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
5	a right to voice complaints or appeals about the organization or the care provided
7	a responsibility to provide information (to the extent possible) that the organization and its practitioners and providers need in order to care
8	a responsibility to follow plans and instructions for care that they have agreed on with their practitioners

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9	a responsibility to understand their health care problems and participate in developing mutually agreed upon treatment goals to the degree possible.
RR 2	Distribution of Rights Statements to Members and Practitioners
	The organization distributes its policy on members' rights and responsibilities to its members and participating practitioners.
ELEMENT A: Distribution of Rights Statement to Members and Practitioners	
	The organization distributes its members' rights and responsibilities statement to:
1	existing members
2	new members
3	existing practitioners
4	new practitioners.
RR 3	Policies for Complaints and Appeals
	The organization has written policies and procedures for the thorough, appropriate and timely resolution of member complaints and appeals. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).
RR 4	Subscriber Information
	The organization provides each subscriber with information needed to understand benefit coverage and obtain care.
ELEMENT A: Subscriber Information	
	The organization provides written information to its subscriber addresses the following factors:
1	benefits and services included in, and excluded from, coverage
2	pharmaceutical management procedures, if they exist
3	co-payments and other charges for which the member is responsible
4	restrictions on benefits that apply to services obtained outside the organization's system or service area
6	how to obtain information about practitioners who participate in the organization
7	how to obtain primary care services, including points of access
8	how to obtain specialty care, behavioral health services and hospital services
9	how to obtain care after normal office hours
10	how too obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services
11	how to obtain care and coverage when out of the organization's service area
13	Requirement removed, not applicable to WMIP.
14	How the MCO evaluates new technology for inclusion as a covered benefit.
ELEMENT B: Translation Services	

NCQA STANDARDS	
	The organization provides translation services within its member services telephone function based on the linguistic needs of its members.
RR 5	Privacy and Confidentiality
	The organization protects the confidentiality of member information and records.
ELEMENT A: Adopting Written Policies	
	The organization adopts written policies and procedures regarding protected health information (PHI) that addresses:
1	information included in notifications of privacy practices
2	access to PHI
3	the process for members to request restrictions on use/disclosure of PHI
4	the process for members to request amendments to PHI
5	the process for members to request an accounting of disclosures of PHI
6	internal protection of oral, written and electronic information across the organization.
ELEMENT B: Special Protection for PHI Sent to Plan Sponsors	
	The organization's policies and procedures prohibit sharing members' PHI with any sponsor without certification that the plan sponsor's documents have been amended to incorporate the following provisions and the plan sponsor agrees to:
1	not use or disclose PHI other than as permitted by the plan documents or required by law
2	ensure that agents and subcontractors of the employer or plan sponsor agree to the same restrictions and conditions as the employer or plan sponsor with regard to PHI
RR 6	Marketing Information
	The organization ensures that communications with prospective members correctly and thoroughly represent the benefits and operating procedures of the organization.
ELEMENT A: Summary Statement of UM	
	Marketing materials for prospective members contain a summary statement of how the organization's utilization management UM procedures work.
ELEMENT B:	
	All organization materials and presentations accurately describe:
1	covered benefits
2	non-covered benefits
3	practitioner and provider availability
4	potential restrictions

NCQA STANDARDS	
ELEMENT C: Communicating with Prospective Members	
	The organization communicates to prospective members, in easy-to-understand language, a summary of its policies and practices regarding the collection, use and disclosure of protected health information. Communication with prospective members includes the following six factors:
1	inclusions in routine notifications of privacy practices
2	the right to approve release of information (use of authorization)
3	access to medical records
4	protection of oral, written and electronic information across the organization
5	the use of measurement data
6	information for employers.
RR 7	Delegation of RR
	If the managed care organization delegates any RR activities, there is evidence of oversight of the delegated activity.
ELEMENT A: Written Delegation Agreement	
	There is a mutually agreed-upon document that describes all delegated activities.
ELEMENT B: Specific Delegated Activities	
	The delegation document describes:
1	the responsibilities of the organization and the delegated entity
2	the delegated activities
3	at least semi-annual reporting to the organization
4	the process by which the organization evaluates delegated entity's performance
5	the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.
ELEMENT C: Provisions for Protected Health Information	
	If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:
1	a list of the allowed uses of protected health information
2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3	a stipulation that the delegate will ensure that sub delegates have similar safeguards
4	a stipulation that the delegate will provide individuals with access to their protected health information
5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur

NCQA STANDARDS	
6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.
ELEMENT D: Pre-Delegation Evaluation	
	For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.
ELEMENT E: Annual Evaluation	
	For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.
ELEMENT F: Reporting	
	For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element B.
ELEMENT G: Opportunities for Improvement	
	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.

EXHIBIT B – Rates and Payments

A. Overview:

The Department shall pay Evercare a per-member, per-month capitated rate for each Medicaid and Medicare Integration Project (MMIP) enrollee. For rate-setting purposes, the Department has grouped the MMIP enrollees into the following three categories:

1. Enrollees who reside in a nursing facility on the day of their enrollment in MMIP. This is known as the **"NF Category**".

2. Enrollees who are either (a) enrolled in the "Community Options Program Entry Services" program (COPES) or (b) new residents of a nursing facility. This is known as the **"Community Category**".

3. Enrollees who belong to neither the NF Category nor the Community Category. This is known as the **"Other Category".**

Each of these categories is further described below.

B. Summary of Payment Rates

The Department has calculated MMIP payment rates that will be in effect during the following two time periods:

1. The time period beginning June 1, 2005 and ending December 31, 2005. These rates can be found on Table D-1a.

2. The time period beginning January 1, 2006 and ending December 31, 2006. These rates can be found on Table D-1b.

C. The NF Category

The Department will pay under the NF Category for enrollees who were residing in a nursing facility on the first day of the month in which the enrollee first became enrolled in MMIP. The base rate consists of two components:

1. A medical services component; and

2. A statewide Aging and Disability Service Administration (ADSA) benefit component. This does not include a prepayment component.

The Department will adjust both of these components by geographical (Tables G-1a and G-1b for MAA and G-2a/G2-b and G-3a/G-3b for ADSA) and age/gender factors (Table E-1a for 2005 and Table E-1b for 2006). The

Department will make the geographical adjustments on a monthly basis. Age is determined based on the enrollee's age on the first of the month following a birthday.

For rate-setting purposes, an enrollee who moves from a nursing facility to an inpatient hospital setting and then returns to the nursing facility – all within the same calendar month – remains in the NF Category.

An enrollee who no longer resides in a nursing facility or is in an inpatient hospital setting as of the first of the month will be moved to either the Community Category or the Other Category. However, if the enrollee is placed back in the nursing facility before the first of the following month, the enrollee will return to the NF Category.

Nursing facility costs are not included in the capitation payment for the NF Category. The Contractor is not at risk for the nursing facility costs.

D. The Community Category

The Department will pay under the Community Category for enrollees who (a) qualify for and receive COPES and (b) were not residing in a nursing facility as of the first of the month in which the enrollee became enrolled in MMIP.

The base rate consists of four components:

1. A medical services component;

2. A statewide ADSA benefit component, which does not include a prepayment component;

3. A prepayment component; and

4. A care coordination component.

The "medical services' component, the "ADSA benefit" component, and the "prepayment" component are subject to be adjusted by geographical (Tables G-1a and G-1b for MAA and G-2a/G2-b and G-3a/G-3b for ADSA) and age/gender factors (Table E-1a for 2005 and Table E-1b for 2006). (The "care coordination" component is not subject to these factors.) The Department will make the geographical adjustments on a monthly basis. Age is determined based on the enrollee's age on the first of the month following a birthday.

Special provisions apply in situations in which an enrollee who is eligible for and receiving COPES is placed in a nursing facility while enrolled in MMIP. In these situations, the Contractor will become responsible for the monthly payment to the nursing facility (minus the statewide ADSA benefit component)

beginning with the first of the month following placement in the nursing facility. When an enrollee in the Other Category is place in a nursing facility, he or she becomes part of the Community Category, for payment purposes.

The Contractor's obligation in this regard will remain in effect for up to 36 months of care of each affected enrollee. The Contractor obligation also extends to the following circumstances:

1. If the enrollee disenrolls from MMIP after being placed in a nursing facility (unless the disenrollment occurs because of the enrollee's death); and/or

2. If the enrollee moves to the community for a period of two months or less.

After the Contractor make the 36 months of payments, the enrollee will be moved to the NF Category for MMIP payment purposes.

If the Contractor terminates this contract, its liability under Section 9.8.5 must be paid within 90 days of the termination date. The liability will assume an annual trend rate of 2.4%.

The Contractor shall pay the case mix rate for all nursing facility payments that are the Contractor's responsibility under this contract.

E. The "Other" Category

The Department shall pay under the Other Category for all enrollees who do not meet the criteria for either the NF Category or the Community Category.

The Other Category includes (but is not limited to) enrollees eligible for Medicaid Personal Care services

The base rate consists of three components:

1. A medical services component;

2. A statewide ADSA benefit component, which does not include a prepayment component; and

3. A prepayment component.

Each of these components are subject to adjustment by geographical (Tables G-1a and G-1b for MAA and G-2a/G2-b and G-3a/G-3b for ADSA) and age/gender factors (Table E-1a for 2005 and Table E-1b for 2006). The Department will make the geographical adjustments on a monthly basis. Age is

determined based on the enrollee's age on the first of the month following a birthday.

When an enrollee in the Other Category is placed in a nursing facility by the Contractor, he or she becomes part of the Community Category for payment purposes and the terms of Section D above apply.

F. Nursing Facility Relocation Payments

The Department will make certain incentive payments to the Contractor if the Contractor is able to place MMIP enrollees in settings that are appropriate but less restrictive than nursing facilities.

In particular, if the Contractor places a member who was in a nursing facility at the time of MMIP enrollment, or a member who both entered the nursing facility while an MMIP enrollee and has been in the nursing facility in excess of 36 months, into an appropriate but less restrictive setting (such as an assisted living facility), then the Contractor will receive $1000 payment for each relocated member month in excess of historical expected relocated member months. The Department will pay a maximum of twelve (12) monthly payments for each enrollee who qualifies.

The Department will calculate and pay the nursing facility relocation payments annually in March of each year and will include payment for any Nursing Facility Relocation Payments earned through December 31st of the previous year.

Exact methodology for determining the baseline and number of relocated member months will be negotiated between DSHS and the Contractor no later than September 30, 2005.